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ABSTRACT

This curriculum for licensed practical nurse contains 18 units. Each unit is divided into modules comprised of task or job-related competencies. A student competency sheet (SCS) provided for each task is organized into this format: unit number and name, module letter and name of the group of related tasks, and number and name of task; performance checklist; test portion listing items needed, task, and standard; and learning activities. Following some SCSs are information sheets, self-check tests, and/or performance checks. The first three units (A,B,C), which deal with employment opportunities, human relations, and charting, reporting, and recording contain no modules, only tasks. The units cover such nursing skills as maintaining a clean, safe environment; caring for personal, nutrition, and elimination needs of patients; assisting with treatments and procedures; coordinating and communicating; medical and surgical asepsis; caring for the terminal patient; administering emergency treatments; establishing sterile areas; preparing patients for examinations or surgery; administering medication; caring for respiratory tract and urinary, gastro-intestinal, and reproductive systems; and performing supervised management procedures. A teacher's guide is available separately--see note. (YLB)

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CE 028 937

STUDENT MATERIAL
for
COMPETENCY-BASED EDUCATION CURRICULUM
for
LICENSED PRACTICAL NURSE

Prepared by

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U S DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
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PREFACE

It is with great pleasure that we bring you this West Virginia competency based education (CBE) curriculum. This Licensed Practical Nurse curriculum was developed for West Virginia under contract by Associated Educational Consultants, Inc. The effort was coordinated by staff of the Bureau of Vocational, Technical and Adult Education.

The Bureau began advocating competency based education in 1974. Since that time West Virginia has produced over 30 CBE curricula in various occupational areas. We also have a number of CBE curricula currently in the process of being developed and/or fieldtested.

This Licensed Practical Nurse curriculum was inserviced and disseminated to West Virginia LPN teachers at regional meetings during the spring of 1980. Additional copies of this curriculum are available from the:

Vocational Curriculum Laboratory
Cedar Lakes Conference Center
Ripley, West Virginia 25271
Phone toll-free: 1-800-642-2670

I trust this material will be of assistance in your program. Any suggestions you may have for improving this curriculum may be sent to our State Curriculum Lab. Through this feedback we plan to continually update and revise our materials.

VOCATIONAL, TECHNICAL AND ADULT EDUCATION

Clarence E. Burdette

Clarence E. Burdette
Assistant State Superintendent of Schools

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STUDENT COMPETENCY SHEETS FOR LICENSED PRACTICAL NURSE CURRICULUM
UNITS A, B, C and I - XVIII

ACKNOWLEDGEMENTS

The development and revision of this Licensed Practical Nursing CBE curriculum was possible due to the direction, support and enthusiasm of:

Betty Jean Smith
Supervisor of Health Occupations
Bureau of Vocational, Technical and Adult Education
State Department of Education
Charleston, West Virginia

The planning, organizing and coordinating of the development of this competency-based curriculum for Licensed Practical Nursing required the working together of many people of specialized skills and abilities. Associated Educational Consultants, Inc., (AEC) relied heavily on members of the Licensed Practical Nursing Task Force, the group of interested and knowledgeable people necessary for providing professional advice on content and procedure. The devoted assistance of Mrs. Lauretta Cole, who succeeded Miss Smith as Supervisor of Health Occupations for the West Virginia Bureau of Vocational, Technical and Adult Education, should be especially noted here, as should be that of Nancy R. Wilson, Executive Secretary, West Virginia State Board of Examiners for Licensed Practical Nurses, and two faithful teachers of practical nursing, Virginia E. Jones of the Garnet Adult Center, Charleston, and Patricia Richardson, Wood County Technical and Career Center, Parkersburg. Other members of the Task Force, all of whom provided valuable advice and assistance, were: India Hosch, Raleigh County Vocational-Technical Center, Beckley; Rachel Lackey, Cabell County Public School Career Center, Huntington; Mary Ann Green and Shirley Wentz, Garnet Adult Center, Charleston; and Sara E. Smith, Ohio Valley General Hospital, Wheeling. Special appreciation is extended to Dr. Fred Harrington, Coordinator of Curriculum Development, Bureau of Vocational, Technical and Adult Education, who so aptly handled the arrangements for the meetings and many details for the project.

The Content Consultants, those teachers who wrote the Learning Activities for the identified competencies, spent many hours developing the curriculum. The success of this curriculum in West Virginia classrooms will be due to their willingness to share their many combined years of experience in the worlds of health care and education. Accordingly, it is appropriate to accord thanks to the following teachers of practical nursing for their contributions: Mary Brothers and Mary Ann Green, Garnet Adult Center, Charleston; Lee Dils, Wood County Vocational School of Practical Nursing, Parkersburg; and Sara E. Smith, Ohio Valley General Hospital, Wheeling.

It will be noted that many of the student competency sheets in this curriculum are the same as those addressed in the CBE curriculum for Nursing Assistant. The writers of these were an enthusiastic group of teachers of nursing assistance programs: Phyllis P. Arnett, Putnam County Vocational-Technical Center, Eleanor; Grace Gibson Brailer, Preston County Educational Center, Kingwood; Diane L. Crane, Hampshire County Career Training Center, Romney; Lottie Dinda, Webster County High School, Webster Springs; and Leona Giardina, Benjamin Franklin Career and Technical Educational Center, Charleston. Two very special contributors must be noted here: Evelyn Sitler, Allied Health Instructor, Boone County Career and Technical Center, the developer of the initial Nursing Assistant CBE curriculum for the State who provided many hours to the efforts to produce the current second edition; and Jane M. Sylves, R.N., B.S., M.Ed., who not only served as a writer but also reviewed, edited and coordinated the composite effort for Nursing Assistant and Licensed Practical Nurse curricula for continuity and professionalism.

A debt of gratitude is owed also to those many people who took time from their busy schedules to respond to the task validation survey: teachers of practical nursing programs, and hospital and nursing care home personnel at both the supervisory and Licensed Practical Nurse levels in West Virginia and Pennsylvania.

STUDENT CURRICULUM

INTRODUCTION

This material is designed as a student Licensed Practical Nurse Competency-Based Education (CBE) Curriculum. It has been developed to facilitate the learning of skills necessary to be a Licensed Practical Nurse. The tasks in this curriculum are those actually performed "on the job". The Student Competency Sheets are intended for use by students and/or the instructor.

A Teacher's Guide accompanies this curriculum. The guide contains an explanation of the curriculum--its validated basis, the construction and the uses. It also contains competencies by job title, an equipment list, a list of references used in the curriculum, and suggested evaluation instruments.

HOW TO USE THIS CURRICULUM

As you read the Table of Contents, you noticed that the competencies of this curriculum have been grouped into major sections called "Units". A "unit" is a major segment of work made up of related tasks.

A sub-group, within a Unit, is called a "Module". Each Module is made up of several closely-related "Tasks". These have been grouped together as a Module because these related skills may be learned at about the same time.

A "Task" is a job-related competency which constitutes logical and necessary steps in the performance of a segment of the worker's overall duties. Another way of saying this is that a task has a definite beginning and ending point, and between the beginning and ending there are definite steps to be performed.

Each Student Competency Sheet (SCS) pertains to a single "task" which requires performance of five or more steps in order to accomplish the task. In other words, when satisfactory performance of all the "steps" is attained, as listed in the "Performance Checklist," the competence required for that "Task" has been mastered.

Turn to a Student Competency Sheet and look at the format.

In the upper section of the SCS (above the first solid line) you see Unit and a Roman numeral and the name of the Unit on the line below the words "Student Competency Sheet". The second line shows Module A or B or C, etc., and the name of the group of related tasks. The third line tells you the number (1, 2, 3, etc.) and the name of the Task. This is the job-related competency.

What To Do With a Student Competency Sheet

The first major section of the SCS is the "Performance Checklist." The steps listed here serve two purposes. First, they tell exactly what must be done to perform the task. The steps are listed in order. The task can be performed by following the Performance Checklist as it is numbered. As the steps are performed, evaluation can be done. Thus, the second use of the Performance Checklist is as a competency-based "test": can this job be done or do skills need to be sharpened in one or more of the steps?

The second section on the SCS tells more about the competency "test." The "Test" portion lists:

1. Items Needed - what will be needed (equipment, people, etc.) to perform the task.
2. Task - what must be done.
3. Standard - how well the task must be done or, in other words, the standard to which the task must be performed.

The last section of the SCS suggests "Learning Activities" which are recommended in order to be able to perform the task. They include things that can be read, seen and heard. And they suggest situations for practicing skills related to the task. Many additional activities are possible. By the time some or all of the Learning Activities have been completed, why and how to perform the task should be mastered. Performance means:

1. Understanding why the task is done and what's involved in understanding the why's.
2. Being able to perform the task efficiently and effectively.

3. Being able to feel comfortable while performing the task and becoming a "good" worker. A "good" worker should be cooperative, confident, and be able to relay confidence to others.

Some Student Competency Sheets are too long to fit on one page. Don't overlook that second page !

SCS Packets

Some Student Competency Sheets will have extra pages immediately following them. These pages may be Information Sheets, which supplement textbook or audio-visual information or give important vocabulary terms, etc. There may also be a Self-Check Test. (Questions on a Self-Check Test should be answered without looking at the answers. After completing the test, then answers can be checked and discussed.) There may be a "Performance Check," which is also a guide. Sometimes the items on the Performance Check are exactly as listed in the Performance Checklist on the SCS; other times, two or more steps may be combined for evaluation purposes.

These supplements to an SCS will be keyed in the upper right-hand corner of the page. For example, I-A-1 means Unit I, Module A, Task 1. When additional pages are included after the first page of a Student Competency Sheet, each page will be identified, for example, as $\underset{2}{\text{I-A-1}}$, $\underset{3}{\text{I-A-1}}$, etc.

The only exceptions to this numbering system are the first three units, such as, Unit A, Employment Opportunities. For these units there are no "Modules"; there are, though, Tasks. To distinguish these units from those which are directly related to nursing skills, the units have been called "A", "B", and "C" and the Tasks are numbered as 1, 2, 3, etc. Therefore, additional pages which accompany the SCS for Task 1 of Unit A, for example, are called $\underset{2}{\text{A-1}}$ and $\underset{3}{\text{A-1}}$.

When working with a Student Competency Sheet, be sure all the pages included for that task are identified. Also, check to see if any other supplemental material is available from your instructor.

LICENSED PRACTICAL NURSE CURRICULUM

TABLE OF CONTENTS

UNIT MODULE TASK

- A. Employment Opportunities
    - 1. Look for a job
    - 2. Write a personal data sheet (Resume)
    - 3. Complete a job application form
    - 4. Prepare for a job interview
- B. Human Relations
    - 1. Understand yourself
    - 2. Understand successful work attitudes
    - 3. Use principles of human relations
    - 4. Use principles of law and ethics
- C. Charting, Reporting and Recording
    - 1. Use simple medical terminology
    - 2. Record patient information in chart form

I. Maintaining a Clean, Safe Environment

- A. Personal Preparation
    - 1. Wash hands
- B. Unit Equipment Care
    - 1. Clean instruments and supplies
- C. Body Mechanics
    - 1. Observe body mechanics and safety measures
    - 2. Position patient in bed
    - 3. Assist with or give range of motion exercises
    - 4. Assist patient to turn, cough and deep breathe
- D. Bed Preparation and Adjustment
    - 1. Adjust the hospital bed
    - 2. Adjust siderails for patient safety
    - 3. Make unoccupied, surgical or open bed
    - 4. Make occupied bed
    - 5. Put footboard or overbed cradle on bed
    - 6. Put alternating pressure mattress on bed

UNIT MODULE TASK

II. Caring for the Personal Needs of Patients

A. Oral Hygiene

1. Assist a conscious patient to maintain oral hygiene
2. Give oral hygiene for a helpless patient
3. Give or assist with oral hygiene (denture care)

B. General Body Hygiene

1. Assist with tub bath
2. Assist with shower
3. Give a back rub
4. Give or assist patient with bed bath
5. Give perineal care
6. Assist with or shave the male patient
7. Care for or assist patient in caring for hair
8. Give shampoo to a bed patient
9. Care for or assist patient in caring for toenails and fingernails

C. Skin Care

1. Assist with preventing bedsores
2. Give skin care to patient with decubitus ulcers
3. Give skin care to comatose or semicomatose patient
4. Give skin care to patient in casts and/or traction
5. Apply restraints
6. Give skin care to patient in restraints

D. Dressing

1. Assist patient in dressing and undressing

E. Care for the Newborn Infant

1. Carry infant
2. Bathe infant
3. Care for umbilical cord
4. Care for female genitalia
5. Dress circumcision
6. Dress infant
7. Feed infant
8. Identify newborn using bracelet, imprints, etc.
9. Weigh and measure the infant
10. Suction infant's respiratory passage
11. Irrigate eyes with silver nitrate

F. Use of Supports for Locomotion and Traction

1. Assist in putting on or removing braces of a patient
2. Assist patient to dangle
3. Assist patient in standing
4. Assist patient in walking
5. Assist patient in walker use
6. Assist patient in using a cane
7. Assist patient in crutch walking
8. Apply or remove skin traction
9. Position trochanter rolls and/or sandbags

UNIT MODULE TASK

G. Moving and Transporting Patients

1. Transfer a helpless patient to and from a stretcher using a transfer sheet
2. Transfer a patient to and from a stretcher using a three-man lift
3. Transport patient by stretcher
4. Teach patient to transport self in wheelchair
5. Assist a patient (who can stand) to and from a wheelchair
6. Move a patient (who cannot stand) to and from a wheelchair
7. Transport patient by wheelchair
8. Use mechanical lifter

III. Assisting with Nutrition and Elimination Needs of Patients

A. Intake

1. Observe, measure and report food and fluid intake
2. Distribute drinking water
3. Assist with serving or feeding the adult or child

B. Elimination

1. Observe, measure and report output of patient
2. Assist patient in using bedside commode or bathroom
3. Assist patient in using a bedpan
4. Assist patient in using urinal
5. Assist with removing or remove fecal impaction

IV. Assisting with Treatments and Procedures

A. Measuring General Body Attributes

1. Measure and record height and weight
2. Measure and record temperature
3. Measure and record respiration
4. Measure and record pulse (radial, temporal, femoral, carotid, pedal)
5. Measure and record pulse (apical)
6. Measure and record blood pressure
7. Time contractions
8. Count and report fetal heart tones

B. Collecting Specimens

1. Collect a routine urine specimen
2. Collect a "clean catch" urine specimen
3. Collect a 24-hour urine specimen
4. Collect urine specimen (infant)
5. Test urine for sugar and acetone
6. Collect sputum specimen
7. Collect stool specimens
8. Collect gastric specimens
9. Collect nose or throat specimens for culture

UNIT MODULE TASK

C. Application of Environmental Treatments

1. Administer tepid baths
2. Administer warm soaks
3. Administer sitz bath
4. Apply heat lamps
5. Apply heating pads
6. Apply local heat applications
7. Apply heat packs
8. Apply hot water bottle
9. Apply local cold applications
10. Apply ice bags
11. Rotate patients using turning frames
12. Operate Circ-O-Lectric bed
13. Set up child-adult mist tent
14. Set up vaporizer

D. Application of Bandages and Supports

1. Apply ace bandages
2. Apply anti-embolic stockings
3. Apply binders
4. Irrigate wounds
5. Apply sterile dressings/bandages
6. Dress burns

E. Drainage, Tubes and Irrigation

1. Assist with or connect catheters and tubing to drainage
2. Measure and record contents of gastric and intestinal drainage bottles
3. Prepare and give a vaginal douche
4. Prepare and give a cleansing enema
5. Assist patient with postural drainage

V. Coordinating and Communicating

A. Admission, Transfer and Discharge Procedures

1. Admit a patient
2. Transfer a patient within the same facility
3. Discharge a patient
4. Secure patient's valuables
5. Complete release forms

B. Communication

1. Assist in placing telephone calls
2. Use the intercom
3. Arrange for a clergy's visit

UNIT MODULE TASK

VI. Medical and Surgical Asepsis

- A. Surgical Asepsis
  1. Prepare equipment and supplies for sterilization
- B. Medical Asepsis
  1. Follow proper isolation techniques (don and remove gown, mask and gloves)
  2. Follow proper isolation techniques (serve and remove diet tray)
  3. Follow proper isolation techniques (dispose of soiled material)
  4. Follow proper isolation techniques (terminal disinfection)
  5. Set up isolation unit
  6. Collect specimen from isolated patient

VII. Caring for the Terminal Patient

- A. Caring for the Body After Death
  1. Assist with post-mortem care

VIII. Administering Emergency Treatments

- A. Artificial Ventilation and Cardiac Compression
  1. Give artificial ventilation to an unconscious adult
  2. Give artificial ventilation to an unconscious infant
  3. Give external cardiac compression to a patient with an unwitnessed cardiac arrest
  4. Insert oral airway
- B. Hemorrhage Control
  1. Control external hemorrhage

IX. Establishing Sterile Areas

- A. Handle Sterile Equipment and Supplies
  1. Open sterile packs
  2. Handle sterile equipment and supplies
  3. Pour sterile solutions
- B. Establish Sterile Field
  1. Set up sterile field

X. Preparing Patients for Examinations or Surgery

- A. Physical Examinations
  1. Assist with physical examinations
  2. Prepare patient for and/or assist with rectal, vaginal, or proctoscopic examinations

UNIT MODULE TASK

B. Surgical Preparation

  1. Give pre-operative skin care
  2. Prepare patient for surgery

XI. Administering Medication

A. Oral Medication

  1. Administer oral medication

B. Parenteral Medication

  1. Administer parenteral medication

XII. Caring for the Respiratory Tract

A. Respiration Aids

  1. Administer oxygen
  2. Suction patient's upper respiratory passage

XIII. Caring for the Respiratory Tract (Tracheostomy)

A. Tracheostomy Care

  1. Suction tracheostomy
  2. Clean inner cannula of tracheostomy

XIV. Caring for the Eye, Ear, Nose & Throat

A. Throat Care

  1. Irrigate throat

B. Care of the Nasal Passages

  1. Irrigate nose

C. Ear Care

  1. Irrigate ear(s)

D. Eye Care

  1. Irrigate eye(s)

XV. Caring for the Urinary System

A. Maintaining Urinary Output and Preventing Infection

  1. Insert a urinary catheter
  2. Remove retention catheter
  3. Irrigate urinary bladder

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UNIT MODULE TASK

XVI. Caring for the Gastro-Intestinal System

- A. Upper Gastro-Intestinal System
    1. Administer gavage feedings
    2. Connect nasogastric tube to suction
    3. Irrigate nasogastric tubing for patency
- B. Lower Gastro-Intestinal System
    1. Insert rectal suppository
    2. Insert rectal tube
    3. Change colostomy dressing
    4. Irrigate colostomy

XVII. Caring for the Reproductive System

- A. Gynecological Care
    1. Insert vaginal medication

XVIII. Performing Supervised Management Procedures

- A. Patient Recording
    1. Record history by patient interview
    2. Prepare incident report
    3. Record nursing care
    4. Transcribe physicians orders
- B. Patient Processing
    1. Develop a patient care plan
    2. Fill out charge slips
    3. Practice evacuation procedures
- C. Inventory Control
    1. Inventory equipment and supplies
    2. Inventory medicines
    3. Inventory narcotics
    4. Prepare requisitions for equipment, supplies or services
- D. Employee Supervision
    1. Orient new employees
    2. Prepare patient care assignments

UNIT A

EMPLOYMENT OPPORTUNITIES

Terminal Objectives

Upon completion of the modules in this unit, you will:

- Know where and how to look for a job.
- Write a personal data sheet (resume).
- Complete a job application form.
- Be prepared for a job interview.

Student Competency Sheet

Unit A: EMPLOYMENT OPPORTUNITIES

Task 1: LOOK FOR A JOB

Performance Checklist

1. Check the Dictionary of Occupational Titles for health occupations titles that interest you.
2. Check the Occupational Outlook Handbook for information relating to each of these jobs.
3. Consult the local telephone book and patient care institutions that hire employees under the job titles that interest you.
4. Make a list of the employers' names, addresses and telephone numbers.
5. Look in the Classified Ads section of local, regional and statewide newspapers for employers that are looking for employees with health care job titles that interest you.
6. Make an appointment with the school placement officer (if one is available) or the guidance person in charge of job placement. Find out what jobs are available on the local, regional, state and national level. (Find out also what degree of training and experience is usually required for these jobs. Discuss with the counselor the possibilities for additional training after high school: schools which offer courses or programs you are interested in, possibilities for financial aid, and how to apply for financial aid.)
7. Visit local employers and find out what the working conditions are, distance needed to travel, employee benefits, competencies needed and salary for the job you are interested in.

Test

Items Needed:
1. What Color Is My Parachute?, Bolles, Penn Speed Press
2. Dictionary of Occupational Titles, U.S. Department of Labor, Employment and Training Administration
3. Occupational Outlook Handbook, U.S. Department of Labor, Bureau of Labor Statistics
4. Local, regional and statewide newspapers
5. Telephone directories (Yellow Pages)
6. Directories of patient care institutions and agencies
7. Paper
8. Pencil

Task: Research the employment opportunities in health care occupations.

Standard:
1. Must be able to identify several (at least three) jobs that interest you.
2. Must be able to describe the responsibilities of the Licensed Practical Nurse.
3. Must be aware of the employment market for jobs that interest you.
4. Must be able to match competencies you have developed with those necessary to obtain a job or jobs that interest you.

Learning Activities

1. Read What Color Is My Parachute?

2. See and participate in Units IX and X, "Job-Seeking Skills," Job Survival Skills Program. (Singer, 1973.)

3. Read Information Sheet A-1. Then, with your class:
   a. Discuss how the responsibilities of the Nursing Assistant, the Licensed Practical Nurse and the Registered Nurse are alike. How are they different?
   b. Discuss the educational requirements for the three occupations.
   c. Discuss employment opportunities and benefits of the three occupations.

4. a. Read Information Sheet A-1a (Health Care Occupations, as listed in the Dictionary of Occupational Titles (4th Edition, 1977). Refer to the Dictionary of Occupational Titles for more complete information, (the 070, 072, 075, 076, 078, 079, 354 and 355 series.)
   b. Choose at least three jobs that interest you. Where are such workers employed? Discuss these jobs with your instructor and/or class.
   c. With your class, discuss how the various health care occupations serve the public (scope of responsibility, scope of services, and interrelatedness).
5. Take notes from a lecture by your instructor on opportunities in nursing and health care.

6. Write separate lists of:
   a. Things you like to do.
   b. Things you do not like to do.
   c. Things you feel you do well.
   d. Things other people have complimented you on.
   e. Equipment you can use.
   f. Jobs you feel you would like to have.
   g. Places you would like to live and work.
   h. Your living expenses when you are working. (Be reasonable--"cut out the fat.")

7. Read the Occupational Outlook Handbook. (Check the index for job titles you selected from the Dictionary of Occupational Titles.) Then, discuss with classmates:
   a. The nature of the work.
   b. Places of employment.
   c. Training, other qualifications, and advancement.
   d. Employment outlook.
   e. Earnings and working conditions.

8. Interview a person who is currently employed as a Licensed Practical Nurse and/or a person employed in a health care setting that interests you.

9. Write a case study of a person who has had at least two years' experience as a Licensed Practical Nurse.

10. Complete all the activities on the Performance Checklist.

11. Look for a job that interests you. If you are actually looking for a job, apply at as many places as you can find. Don't stop with one and "just hope."

12. Read Chapter 38, General Office Practice, 3rd Ed., Archer, Brecker, Frakes, Stewart. (McGraw-Hill, 1968) or Part 49, General Business for Economic Understanding, 11th Ed., Debrum, Haines, Malsbary, Daughtrey. (Southwestern Publishing, 1976).

INFORMATION SHEET A-1

LOOK FOR A JOB

The following three Allied Health occupations all provide direct nursing care. These are the descriptions as listed in the Dictionary of Occupational Titles (4th Edition, U.S. Department of Labor). Any differences between these job descriptions and those in local patient care facilities will be pointed out by your instructor.

1. D.O.T. Code 355.764-014

NURSE AIDE (Hospital Attendant; Nursing Assistant)

Assists in care of hospital patients, under direction of nursing and medical staff:

Answers signal lights and bells to determine patients' needs.

Bathes, dresses and undresses patients.

Serves and collects food trays and feeds patients requiring help.

Transports patients to treatment units, using wheelchair or wheeled carriage, or assists them to walk.

Drapes patients for examinations and treatments, and remains with patients performing such duties as holding instruments and adjusting lights.

Dusts and cleans patients' rooms.

Changes bed linens, runs errands, directs visitors and answers telephone.

Takes and records temperature, pulse and respiration rates, and food and liquid intake and output, as directed.

May apply compresses and hot water bottles.

May clean, sterilize, store, prepare and issue dressing packs, treatment trays and other supplies, and be designated as NURSE AIDE, CENTRAL SUPPLY.

May prepare patients for delivery and clean delivery rooms, and be designated as NURSE AIDE, DELIVERY.

May bathe, weigh, dress and feed newborn babies and be designated as NURSE AIDE, NURSERY.

May clean, sterilize and assemble into packs, supplies and instruments used in surgery, and maintain cleanliness and order of operating rooms and be designated as NURSE AIDE, SURGERY.

Information Sheet A-1 - (Continued)

2. D.O.T. Code 079.374-014

NURSE, LICENSED PRACTICAL

Cares for ill, injured, convalescent, and handicapped persons in hospitals, clinics, private homes, sanitariums, and similar institutions:

Takes and records temperature, blood pressure, and pulse and respiration rate.

Dresses wounds, gives enemas, douches, alcohol rubs, and massages.

Applies compresses, ice bags, and hot water bottles.

Observes patients and reports adverse reactions to medical personnel in charge.

Administers specified medication, and notes time and amount on patients' charts.

Assembles and uses such equipment as catheters, tracheotomy tubes, and oxygen suppliers.

Performs routine laboratory work, such as urinalysis.

Sterilizes equipment and supplies, using germicides, sterilizer, or autoclave.

Prepares food trays and feeds patients.

Records food and fluid intake and output.

Bathes, dresses, and assists patients in walking and turning.

Cleans rooms, makes beds, and answers patients' calls.

Washes and dresses bodies of deceased persons.

Must pass state board examination and be licensed.

May assist in delivery, care, and feeding of infants.

Information Sheet A-1 - (Continued)

3. D.O.T. Code 075.374-010

NURSE, GENERAL DUTY (Staff Nurse)

(Note: The 075 group--Registered Nurses--includes occupations concerned with administering nursing care to the ill or injured. Includes nursing administration and instruction; and public health, industrial, private duty, and surgical nursing. Licensing or registration is required.)

Renders general nursing care to patients in hospital, infirmary, sanitarium, or similar institution:

Administers prescribed medications and treatments in accordance with approved nursing techniques.

Prepares equipment and aids physician during treatments and examinations of patients.

Observes patient, records significant conditions and reactions, and notifies supervisor or physician of patient's condition and reaction to drugs, treatments, and significant incidents.

Takes temperature, pulse, blood pressure, and other vital signs to detect deviations from normal and determine progress of patient.

May rotate among various clinical services of institution, such as obstetrics, surgery, orthopedics, outpatient and admitting, pediatrics, psychiatry, and tuberculosis.

May prepare rooms, sterile instruments, equipment, and supplies, and handing, in order of use, to assist surgeon or obstetrician in operations and deliveries.

May make beds, bathe and feed patients, and assist in their rehabilitation.

May serve as leader for group of personnel rendering nursing care to number of patients.

INFORMATION SHEET A-1a

LOOK FOR A JOB

HEALTH CARE OCCUPATIONS

As listed by groups in the
Dictionary of Occupational Titles (4th Ed., 1977)

1. Group 070: PHYSICIANS AND SURGEONS

2. Group 075: REGISTERED NURSES

   This group includes occupations concerned with administering nursing care to the ill or injured. Includes nursing administration and instruction; and public health, industrial, private duty, and surgical nursing. Licensing or registration is required.

   CONSULTANT, EDUCATIONAL, STATE BOARD OF NURSING
   DIRECTOR, COMMUNITY HEALTH NURSING
   DIRECTOR, EDUCATIONAL, COMMUNITY HEALTH NURSING
   DIRECTOR, NURSING SERVICE
   DIRECTOR, OCCUPATIONAL HEALTH NURSING
   DIRECTOR, SCHOOL OF NURSING
   EXECUTIVE DIRECTOR, NURSES' ASSOCIATION
   NURSE INSTRUCTOR
   NURSE, SCHOOL
   NURSE, STAFF, COMMUNITY HEALTH
   INSTRUCTOR, PSYCHIATRIC AIDE
   NURSE, CONSULTANT
   NURSE, HEAD
   NURSE, SUPERVISOR
   NURSE, SUPERVISOR, COMMUNITY HEALTH NURSING
   NURSE, SUPERVISOR, OCCUPATIONAL HEALTH NURSING
   NURSE PRACTIONER
   NURSE-MIDWIFE
   NURSE ANESTHETIST
   NURSE, GENERAL DUTY
   NURSE, OFFICE
   NURSE, PRIVATE DUTY
   NURSE, STAFF, OCCUPATIONAL HEALTH NURSING

3. Group 076: THERAPISTS

   This group includes occupations concerned with the treatment and rehabilitation of persons with physical or mental disabilities or disorders, to develop or restore functions, prevent loss of physical capacities, and maintain optimum performance. Includes occupations utilizing means, such as exercise, massage, heat, light, water, electricity, and specific therapeutic apparatus, usually as prescribed by a physician; or particupation in medically oriented rehabilitative programs, including educational, occupational, and recreational activities.

Information Sheet A-1a - (Continued)

AUDIOLOGIST
SPEECH PATHOLOGIST
COORDINATOR OF REHABILITATION SERVICES
OCCUPATIONAL THERAPIST
PHYSICAL THERAPIST
ORIENTATION THERAPIST FOR THE BLIND
PHYSICAL THERAPIST ASSISTANT
CORRECTIVE THERAPIST
OCCUPATIONAL THERPY ASSISTANT

4. Group 078: OCCUPATIONS IN MEDICAL AND DENTAL TECHNOLOGY

This group includes occupations concerned with the application of technical knowledge in fields of medicine or dentistry for examination and treatment of patients or for research. Occupations occur in a doctor's or dentist's office, hospital, or laboratory.

MEDICAL TECHNOLOGIST, TEACHING SUPERVISOR
MEDICAL TECHNOLOGIST, CHIEF
RADIOLOGIC TECHNOLOGIST, CHIEF
CHEMISTRY TECHNOLOGIST/ Medical Technologist,
  Chemistry; technologist, biochemistry
MICROBIOLOGY TECHNOLOGIST/ Medical Technologist,
  bacteriology.
ORTHOTIST
PROSTHETIST
CYTOTECHNOLOGIST
DENTAL HYSIENTIST/ Oral Hygienist
MEDICAL TECHNOLOGIST
NUCLEAR MEDICAL TECHNOLOGIST/ Radioisotope
  Technologist
ORTHOTICS ASSISTANT
PROSTHETICS ASSISTANT
TISSUE TECHNOLOGIST
AUDIOMETRIST
DIALYSIS TECHNICIAN
ELECTROCARDIOGRAPH TECHNICIAN
ELECTROENCEPHALOGRAPHIC TECHNOLOGIST
RADIOLOGIC TECHNOLOGIST
ULTRASOUND TECHNOLOGIST
MEDICAL LABORATORY ASSISTANT
MEDICAL LABORATORY TECHNICIAN
CEPHALOMETRIC ANALYST
LABORATORY ASSISTANT, BLOOD AND PLASMA

5. Group 079: OCCUPATIONS IN MEDICINE AND HEALTH, N.E.C.

This group includes occupations, not elsewhere classified, concerned with the health care of humans or animals.

Information Sheet A-1a - (Continued)

HEALTH PHYSICIST
MEDICAL PHYSICIST
CHIROPRACTOR
DOCTOR, NATUROPATHIC
OPTOMETRIST
PODIATRIST
EMERGENCY MEDICAL SERVICES COORDINATOR
PUBLIC HEALTH EDUCATOR
SANITARIAN
INSERVICE COORDINATOR, AUXILIARY PERSONNEL
HYPNOTHERAPIST
INDUSTRIAL HYGIENIST
SUPERVISOR, CENTRAL SUPPLY
COMMUNITY SERVICES AND HEALTH EDUCATION OFFICER
MEDICAL RECORD ADMINISTRATOR
ACUPUNCTURIST
RESPIRATORY THERAPIST
CHIROPRACTOR ASSISTANT
OPTOMETRIC ASSISTANT
PHYSICIAN ASSISTANT
MEDICAL ASSISTANT
MEDICAL SERVICE TECHNICIAN
DENTAL ASSISTANT
ORTHOPTIST
EMERGENCY MEDICAL TECHNICIAN
NURSE, LICENSED PRACTICAL
PODIATRIC ASSISTANT
SURGICAL TECHNICIAN

6. Group 354: UNLICENSED BIRTH ATTENDANTS AND PRACTICAL NURSES

This group includes occupations concerned with bathing patients, taking and recording pulse and temperature readings, giving injections, assisting women in childbirth, caring for and feeding infants, giving first aid, and performing similar routine nursing tasks. Knowledge is acquired primarily through practical experience. (Licensed practical nursing occupations are included in Group 079.)

NURSE, PRACTICAL

(For practical nurses meeting State licensing requirements, see NURSE, LICENSED PRACTICAL.)

HOME ATTENDANT/ Home Health Aide.
FIRST-AID ATTENDANT

7. Group 355: ATTENDANTS, HOSPITALS, MORGUES, AND RELATED HEALTH SERVICES

This group includes occupations concerned with attending to the physical comfort, safety, and appearance of patients; performing routine menial tasks; and assisting in conducting occupational and recreational therapy.

Information Sheet A-la - (Continued)

PHYSICAL THERAPY AIDE/Physical Therapy Attendant
AMBULANCE ATTENDANT
OCCUPATIONAL THERAPY AIDE
PSYCHIATRIC AIDE/Assistant Therapy Aide;
  Asylum Attendant; Charge Attendant;
  Psychiatric Attendant; Ward Attendant
MORGUE ATTENDANT
CHILD-CARE ATTENDANT, SCHOOL
NURSE AIDE/Hospital Attendant/ Nursing Assistant
ORDERLY
FOOD SERVICE WORKER, HOSPITAL/Dietary Aide/
  Diet-Kitchen Aide/Tray Worker
HOSPITAL ENTRANCE ATTENDANT/Hospital Messenger
CLOTHES ROOM WORKER

Student Competency Sheet

Unit A: EMPLOYMENT OPPORTUNITIES

Task 2: WRITE A PERSONAL DATA SHEET (RESUME)

Performance Checklist

1. Gather all the important information about you in the following areas:
   a. Education you have had.
   b. Work experience you have had.
   c. Your accomplishments or honors.
   d. Relevant personal information.
   e. Names of people who know what type of person you are.
2. Assemble this information in outline form as follows:
   a. Personal information
   Name, address, telephone number, year of birth, health, height, weight.
   b. Education and Training
   Name and address of all schools, grade level completed, work-related subjects completed. If your instructor maintains a list of competencies you have mastered, include the information that such a list is available to your prospective employer. If you are licensed, include your state number.
   c. Military Service
   Branch of service, rank at time of discharge, type of duty assignments.
   d. Employment (Work Experience)
   List in order, beginning with the most recent and going back to your first employment. List: employer, dates, job title, duties, salary, supervisor and reason for leaving. Include work done on a co-op or on a volunteer basis. Briefly describe each job you had.
   e. Awards, Licenses, Honors and Organizations
   Include any honors or offices held during school years in VICA or other club activities.
   f. Interests and hobbies
   g. Personal References
   Names, addresses and telephone numbers of three people you feel would recommend you for employment. (NOTE: Always ask the person first before using someone's name.)

Test

Items Needed:
1. Paper
2. Pen or pencil
3. Typewriter (recommended)

Task: Organize personal information about yourself to write a personal data sheet (sometimes called a "resume").

Standard:
1. The personal data sheet will be complete.
2. The personal data sheet will be written in a neat, orderly fashion (typewritten if possible).

Learning Activities

1. If you do not already have a social security card, ask the school guidance counselor or placement officer how you can get one.

2. Develop a personal data sheet (resume) by following the steps outlined in the Performance Checklist:

   a. Use Information Sheet A-2 as a guide to assemble information, then
   b. Write (neatly in pen) or type a personal data sheet (resume). You may use Information Sheet A-2 as a guide.

3. Read page 585, General Business for Economic Understanding, 11th Ed., DeBrum, Haines, Malsbary, Daughtrey. (Southwestern Publishing, 1976).

4. See and participate in Unit XI, "Resume," of Job Survival Skills Program. (Singer, 1973.)

INFORMATION SHEET A-2

WRITE A PERSONAL DATA SHEET (RESUME)

NANCY JEAN JOBSEEKER

Personal Data:

Address:	124 Main Street Charleston, West Virginia 25000
Telephone:	(304) 123-4567
Date of Birth:	August 28, 1961
Physical Condition:	Excellent, Height--5'4"; Weight--125

Job Objective: Licensed Practical Nurse

Licensure: Successfully completed requirements for licensure as set forth by the West Virginia Board of Examiners for Licensed Practical Nurse. (#xxxx; June, 1980).

Education:

John Quincy Adams Career Center 111 Mt. Vernon Road Charleston, West Virginia 25000	Licensed Practical Nursing Graduated June, 1980
Thomas Jefferson High School 124 Independence Avenue Charleston, West Virginia 25000	Graduated 1979. (Academic) Licensed Practical Nurse
James Madison Junior High School 248 Independence Avenue Charleston, West Virginia 25000	Attended 1973-1976
James Monroe Elementary School 400 Independence Avenue Charleston, West Virginia 25000	Attended 1967-1973

Information Sheet A-2 - (Continued)

Work Experience:

Employer: Benjamin Franklin Nursing Home
489 Revolutionary Street
Charleston, West Virginia 25000

Dates: June, 1979 - September, 1979
July, 1978 - September, 1978 (Volunteer)

Job Title: Nurse Aide

Duties: Transporting and assisting patients; changing linens; reading to patients.

Salary: $2.85 per hour

Supervisor: Mrs. Bess Truemann

Reason for Leaving: Return to school

Awards, Honors and Organizations:

- Future Nurses of America
  - President (1978-79)
  - Treasurer (1977-78)
- Student Council Representative--James Madison Junior High School (1975-76)

Interests and Hobbies:

Reading, jogging, bowling

References:

Mrs. Bess Truemann
Benjamin Franklin Nursing Home
489 Revolutionary Street
Charleston, West Virginia 25000 (304-347-0000)

Mrs. Nancy Carter
Practical Nursing Instructor
John Quincy Adams Career Center
111 Mt. Vernon Road
Charleston, West Virginia 25000 (304-000-3470)

Mr. Lyndon Jackson
126 Main Street
Charleston, West Virginia 25000 (304-123-3456)

Student Competency Sheet

Unit A: EMPLOYMENT OPPORTUNITIES

Task 3: COMPLETE A JOB APPLICATION FORM

Performance Checklist

1. Read the application form carefully before filling it out.
2. Refer to your Personal Data Sheet (resume). Fill out all the blanks as they apply to you.
3. Draw a short line in the blanks that do not apply, or write N/A (not applicable).
4. Either print or write, as directed. (NOTE: Never use both.)
5. Use either a pen or a clear-writing pencil. (NOTE: Never use both.)
6. Do not use abbreviations.
7. Be neat, accurate and honest with all information.
8. Always write your signature.
9. Do not write in the blanks that are to be used by the company.

Test

Items Needed:
1. Your Personal Data Sheet
2. Job application form
3. Ballpoint pen or pencil

Task: Complete the application form.

Standard:
1. The directions printed on the application form will be completed with 100% accuracy.
2. All information filled in on the application will be spelled correctly.
3. The completed application will appear in a neat form.
4. The completed application must be approved by your instructor.

Learning Activities

1. Locate the following information needed to successfully complete a job application form: (See Information Sheet A-3.)

   A. Personal Data
      (1) Date of Birth (DOB)
      (2) Place of Birth (POB)
      (3) Social Security Number (SSN)
      (4) Telephone number, including area code
      (5) Residence, including ZIP code
      (6) Marital status (if listed)
      (7) Picture (if requested)

   B. Educational Information
      (1) High school credits
      (2) Courses taken
      (3) Class rank
      (4) Co-curricular activities
      (5) Extra-curricular activities
      (6) Special awards and recognitions

C. Military information
D. Previous employment

2. Read and learn the terms listed on Information Sheet A-3a ("Terms to Know to Fill Out a Job Application"). Discuss these terms with your class.

3. Take the self-check test supplied by your instructor. (See Self-Check Test A-3.)

4. Practice completing an application for employment (Information Sheet A-3).

5. Fill out a different application form provided by your instructor or an employer. Use the Performance Checklist whenever needed.

6. See and participate in Unit XII, "Packaging Your Skills: Application" in Job Survival Skills Program, Singer Career Systems, Rochester, NY, 1973.

7. Read: Pages 585-588, General Business for Economic Understanding, 11th Ed., DeBrum, Haines, Malsbary, Daughtrey, (Southwestern Publishing Co., 1976), or pages 522-523, General Office Practice, 3rd Ed., Archer, Brecker, Frakes, Stewart, (McGraw-Hill Book Company, 1968).

INFORMATION SHEET A-3

APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION

Print Mr.
Name Ms.

Last First Middle

Address:

No. and Street

City State Zip Code

Telephone: / / Social Security No. - -

Area Code No.

Is Your Age (check one) under 18____ 18-65____ over 65____

Are you a citizen of the U.S.A.? ____Yes____No

If you are not a citizen of the U.S.A., do you have a legal right to remain permanently in the U.S.? ____Yes ____No

JOB INTEREST

Position Desired:

Date Available:

Wages or salary expected $ Hr. Per Wk. Mo.

Other Work for Which You Are Qualified

Willing to Work Night Shift Yes No

Have You Ever Applied for a Security Clearance? Yes No

Have You Ever Been Granted A Security Clearance? ____Yes____No

Type of Clearance Granted:

U.S. MILITARY HISTORY

Branch Date Entered / /

Date Discharged / /

Rank When Discharged

Armed Forces Reserve Branch or National Guard____Active____Inactive

List Any Special Skills Acquired While In U. S. Armed Forces

Information Sheet A-3 (Continued)

EDUCATIONAL BACKGROUND

School Name and Address of School include Grade School, High School, Trade School, College or Business School, Night School, Correspondence School, Other	Dates of Attendance		Diploma Degree of Certificate	Course of Specialty
	From	To		

SCHOOL ACTIVITIES

Sports:	Student Government: List Others

Clubs or Fraternities (Sororities): List Offices

Honorary Clubs:

Academic Honors:

EMPLOYMENT HISTORY

Please Cover Employment for Past 10 Years, Including U. S. Military

Date	Name & Address Employer	1. Job Title 2. Department 3. Name of Supervisor	Describe Major Duties	Wages	Reason For Leaving
From Mo. Yr To Mo. Yr.		1. 2. 3.		Starting $____per Final $____per	
From Mo. Yr. To		1. 2. 3.		Starting $____per Final $____per	

Information Sheet A-3 (Continued)

REFERENCES

Please Give Professional and Personal References

Name (First, Middle, Last)	Address (Street, City, State)	Occupation (Position or Title)

PRE-EMPLOYMENT STATEMENT

I voluntarily give this Company the right to make a thorough investigation of my past employment and activities, agree to cooperate in such investigation, and release from all liability or responsibility all persons, companies or corporations supplying such information.

I consent to taking the pre-employment physical examination and such future physical examinations as may be required by the Company. I agree to wear or use protective clothing or devices as required by the Company and to comply with the safety rules.

If employed by the Company, I understand that this employment is subject to the security policies of the Company. I further understand that if the position for which I am hired requires access to classified information and I am not able to obtain a security clearance, I will not be allowed to work in this position. My employment with the Company in a position not requiring security clearance depends upon the existence of such a position for which I am qualified.

I further understand that any false answers or statements made by me on this application or any supplement therein or in connection with the above mentioned investigation will be sufficient grounds for immediate discharge.

Applicant's Signature____ Date______________

INFORMATION SHEET A-3a

TERMS TO KNOW TO FILL OUT A JOB APPLICATION

1. Nationality - country where a person is born
2. Guardian - person in charge of the legal care of a youth
3. Marital status - single, married, divorced or widowed
4. Number of dependents - individuals who depend upon you for their support
5. Ethnic group - caucasian (white), negroid (black), Indian, Asian, other
6. Limitations - health or physical condition that may hinder a person on the job
7. Capabilities - things you can do well
8. Compensation - pay for time not able to work
9. Naturalized citizen - a person who has gone through the legal process to become a U.S. citizen
10. Natural born citizen - a person who is born in a country
11. Fringe benefits - things given an employee other than money
12. Wage - the hourly rate of pay
13. Salary - monthly or yearly contract payments
14. Supervisor - a person who works for another person or company
15. Employee - a person who works for another person or company
16. Employer - a person or company who hires another
17. O.A.S.I. - Old Age Survivors Insurance
18. Deduction - that which is taken from a pay check
19. Federal withholding - tax money taken out for the U.S. Government.
20. State withholding - tax money taken out by the State Government
21. Annuity - a form of saving money
22. Gross Pay - the total amount paid before deductions
23. Take home pay - the amount that is taken home
24. Management - those who make decisions
25. Personnel Manager - person who is in charge of people
26. Job interview - the person-to-person contact between employee and employer
27. F.I.C.A. - (Federal Insurance Compensation Act) - money taken out for Society Security.

SELF-CHECK TEST A-3

Define the following terms:

1. Nationality - ____________________
2. Guardian - ____________________
3. Marital status - ____________________
4. Number of dependents - ____________________
5. Ethnic group - ____________________
6. Limitations - ____________________
7. Capabilities - ____________________
8. Compensation - ____________________
9. Naturalized citizen - ____________________
10. Natural born citizen - ____________________
11. Fringe benefits - ____________________
12. Wage - ____________________
13. Salary - ____________________
14. Supervisor - ____________________
15. Employee - ____________________
16. Employer - ____________________
17. O.A.S.I. - ____________________
18. Deduction - ____________________
19. Federal withholding - ____________________
20. State withholding - ____________________
21. Annuity - ____________________
22. Gross Pay - ____________________
23. Take home pay - ____________________
24. Management - ____________________
25. Personnel Manager - ____________________
26. Job interview - ____________________
27. F.I.C.A. - ____________________

Student Competency Sheet

Unit A: EMPLOYMENT OPPORTUNITIES

Task 4: PREPARE FOR A JOB INTERVIEW

Performance Checklist

1. Write a letter of application and ask for an interview. Or, go directly to the employer and ask for an interview.
2. Secure as much information as possible about the institution and its services before the interview. Know what kinds of patients are served and the qualifications you must have to perform the job.
3. Get a good night's sleep before the interview.
4. Before going to the interview, make sure you have taken a shower or bath, brushed your teeth, combed your hair and put on clean, neat clothes.
5. Be prompt for the interview.
6. Go alone.
7. Look pleasant.
8. Introduce yourself in a quiet, pleasant way.
9. Shake hands firmly.
10. Sit erect (if the prospective employer indicates that you should sit down).
11. Avoid signs of nervousness (such as tapping fingers or foot).
12. Look the interviewer in the eye.
13. Be ready to describe your competencies and qualifications to the interviewer.
14. Be ready to take a performance test if the job requires it.
15. Leave discussion of salary to the end of the interview.
16. Thank the interviewer before you leave.
17. Every interview should be followed up with a letter of appreciation.

Test

Items Needed:
1. An employer (either an actual prospective employer or another student who will act as interviewer).
2. List of competencies you have developed (or a simulated list).
3. Pen.
4. List of questions to ask, things to remember at the interview.

Task:
1. Prepare for a job interview.
2. Have a job interview (by a prospective employer or another student).

Standard: Your instructor will evaluate your preparation and performance.

Learning Activities

1. Complete the Pretest (Self-Check Test A-4).

2. Read page 588, General Business for Economic Understanding, 11th Ed., DeBrum, Haines, Malsbary, Daughtrey, (Southwestern Publishing Co., 1976), or read pages 519-521, General Office Practice, 3rd Ed., Archer, Brecker, Frakes, Stewart (McGraw-Hill, 1968).

3. Write a letter of application. (See Information Sheet A-4.)

4. Develop a list of nursing competencies you have mastered.

5. See and participate in Unit XIII, "Interview," Job Survival Skills Program (Singer, 1973.)

6. Read the following Information Sheets for this task:
   a. "Interviewing: A Skill, Not a Mystery" (Information Sheet A-4a)
   b. "Some Frequently Asked Questions During the Interview" (Information Sheet A-4b)
   c. "Things to Remember at the Interview" (Information Sheet A-4c)
   d. "Factors Which Frequently Lead to Rejection of the Applicant" (Information Sheet A-4d)

7. Before going to the interview, develop a check list of things to ask.

8. Before going to the interview, develop a list of things to remember to tell the interviewer about yourself. Keep this in a coat pocket or wallet, but use it only when needed.

9. Complete "Check List to be Used Before Going for an Interview" (Information Sheet A-4e)

10. Practice with another student. Take turns being the interviewer and the applicant. Use the Performance Checklist as a guide.

SELF-CHECK TEST A-4

Pretest*

1. Prior to an interview, a well-prepared applicant should:
   a. Rely on memory to answer or fill out any questions.
   b. Be prepared to answer questions by composing his own questions and answers.
   c. Answer all questions "off the top of the head."

2. For the interview, an applicant should:
   a. Wait for the interviewer to explain what the company's business is.
   b. Not worry about the company and just interest himself/herself in a specific job.
   c. Research the company.

3. In preparation for the interview, an applicant should:
   a. Locate the company prior to the interview.
   b. Leave early enough to find the company on the day of the interview.

4. Appropriate dress for an interview might be:
   a. Blue jeans and a shirt.
   b. Your best dress-up clothes.
   c. Clean, neat clothes appropriate to the company and the job you're applying for.

5. When an interview is scheduled for 10:00 a.m., the applicant should:
   a. Not worry about being ten (10) minutes late.
   b. Be punctual.
   c. Arrive an hour early.

6. When speaking with the interviewer, an applicant should:
   a. Emphasize good points.
   b. Tell the interviewer he/she didn't do so well in some skills or courses.
   c. Avoid the whole truth.

7. To answer any questions an interviewer might ask, an applicant should:
   a. Be honest, factual and sincere.
   b. Make up something if he doesn't know the answer.
   c. Lie if necessary to make a good impression.

8. If asked, "What can you do?" an applicant should:
   a. Avoid saying, "I'll do anything."
   b. Tell the interviewer, "It depends."
   c. Say, "I'll do anything."

9. When speaking to an interviewer, an applicant should:
   a. Try to look the interviewer in the eye.
   b. Read the pre-written paper.
   c. Look around the room.

Self-Check Test (Continued)

10. An appropriate response to end an interview might be:
    a. "Thank you."
    b. "See you later."
    c. "Please pick me."

11. If an applicant never hears from the company, he/she should:
    a. Never apply for another job.
    b. Tell friends never to apply there.
    c. Not be discouraged.

12. If an applicant doesn't get the job, he/she should:
    a. Analyze why.
    b. Forget about the interview.
    c. Blame it on the interviewer.

13. If an applicant doesn't get the job, he/she should:
    a. Mourn.
    b. Keep trying.
    c. Be content to be unemployed.

*No answers are provided for this pretest. Instead, use each item as a discussion item with your instructor and class. Also, look for the correct answers as you complete the other Learning Activities for this task.

INFORMATION SHEET A-4

124 Main Street
Charleston, West Virginia 25000
September 10, 1980

Mr. James Polk
Personnel Director
Ace Nursing Home
253 Brownlee Road
Charleston, West Virginia 25003

Dear Mr. Polk:

In response to your ad for a Licensed Practical Nurse in the Sunday, September 9, 1980, edition of The Charleston Post, I am enclosing a resume.

I have recently completed the Licensed Practical Nursing program at John Quincy Adams Career Center, where I satisfactorily completed all the required competencies for this program as well as those required for licensure from the West Virginia Board of Examiners for Licensed Practical Nurse. My LPN registration number is xxxx, June 1980.

My experiences in school and in the Nurses Aide position at Benjamin Franklin Nursing Home will indicate to you that I am very much interested in a career in Allied Health as a Licensed Practical Nurse. You will note also that I have had a great deal of leadership experience through Future Nurses of America, which will indicate both my interest in nursing and potential to be an asset to your Nursing Home.

I would appreciate your consideration of me as a member of your organization. I can be contacted for an interview at 123-4567.

Thank you very much.

Sincerely,

Nancy Jean Jobseeker

Enclosure

INFORMATION SHEET A-4a

INTERVIEWING: A SKILL, NOT A MYSTERY*

I. GETTING READY FOR AN INTERVIEW

1. Figure out what you really want to do. Be specific. Make a list of exactly what you want AND of what you don't want. Look at what you've done in the past--education, summer jobs, hobbies, clubs, etc. Get help from your counselor. You've got to have some idea of what you're after.

2. Learn everything you can about the company. Read any literature you can find to learn about job openings and what they are like, company benefits, etc. Talk to people who work or have worked for the company. The more you know before the interview, the fewer unnecessary questions you'll have to ask--and the interviewer is bound to be impressed if you've "done your homework."

3. Role-play an interview with a friend, taking turns as interviewer and applicant. This way you'll know the routine of an interview and will be more relaxed when it's for real. Talk to others who have been interviewed (by the company you're applying to if possible).

4. Be fair to yourself--be sure the interviewer knows all about you and what you can do. This means learning to fill out job applications correctly. DON'T give incomplete answers. DON'T fill out the application hurriedly--be sure it's neat and written as clearly as you can. Print everything but your signature. You'll do a better job of giving all the information about yourself if you take along your Personal Data Sheet (Resume). (Some company's use an information form similar to the Personal Data Sheet in addition to the job application form.)

II. WHAT INTERVIEWERS LOOK FOR

1. An interview is short. The interviewer must learn a lot about you in a very short time. The basic purpose of the interview is to exchange enough information to screen you from a number of other applicants. They have to decide whether the company should talk with you further and keep your name on the applicant list.

2. First impressions will be noted. The interviewer usually makes notes of the first impression, so making a good first impression is an asset to you and to the company you'd like to work for. During the interview, other general traits will also be noted: poise, ability to communicate, social skills and personality. In short, the interviewer only sees you once and the impression you leave is what the interviewer sees as a general picture of you.

3. An interviewer wants to find out exactly what you think you want and why, what kind of work you're looking for, and how interested you are in that work. Interviewers also look for career goals, drive to accomplish those goals, interest in further education, further training and such other things as preferred location and your willingness to relocate if necessary.

Information Sheet A-4a - (Continued)

4. The purpose of telling the interviewer what you've done is to help indicate if your work interests seem to match your talents. Your qualifications will be reviewed: jobs, grades, skill level, special training, hobbies and extracurricular activities.

5. If you do seem qualified for a certain kind of work, the interviewer has to see if the company has a job area that might match your interests. If so, they'll explain the details of the work and see if you are interested and just how interested.

III. HOW TO ACT DURING AN INTERVIEW

1. Be yourself. DON'T "act." The only company you are likely to be happy working for is one that likes you just the way you are. Very few people can play roles well enough to fool an interviewer, who has met and talked to a great many people.

2. Don't overdo it. Act professionally and naturally. Be on time! Be friendly, but not too casual. Be courteous. Have your thoughts and questions well organized.

3. Don't be afraid to tell the interviewer all about yourself. Don't answer questions with just a yes or no. Take this opportunity to tell about your goals and strong points. This may alert an interviewer to terrif[illegible] information about you that didn't show up on the resume. Open up!

4. Tell it like it is. A lie is often an attempt to hide a problem that will only get in the way later. Be completely honest. If you have no interest in a particular kind of work or job, say so. You should be trying to screen the company too.

IV. WHAT TO EXPECT AFTER AN INTERVIEW

1. Don't expect to be hired on the spot. It's usually not the role of the interviewer to do the hiring. Interviewers only make screening decisions to determine whether the company should talk with an applicant further. By the end of the interview, most companies will try to tell you as clearly as possible what to expect next.

2. Interviewers rarely promise anything, even when they think the applicant is highly qualified. But if they feel you'll be under active consideration, they'll usually indicate that you can expect a second interview or that they'll contact you later.

3. Write to the interviewer after the interview if you're interested. Mention the interviewer's name, time and date of the original interview plus important points discussed. If it's a small company, especially, and you haven't heard anything in a week, call back. Sometimes applications get moved to the bottom of the stack. Remind the interviewer [illegible] your interest. Keep on learning about the company.

Information Sheet A-4a - (Continued)

4. If you get a "NO" answer, it's probably because your interests and the company's don't match. Don't worry, just analyze "why." Almost everyone hears a "no" before a job is landed. Look at it as a learning experience: you've learned about interviewing, about your likes, a company's needs, and you've got great experience to go ahead to another company much better suited to you.

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*Adapted from "What Students Should Know About Interviewing," General Electric, Educational Communications Programs, Fairfield, CT 06431, 1978.

INFORMATION SHEET A-4b

SOME FREQUENTLY ASKED QUESTIONS DURING THE INTERVIEW*

1. What are your future vocational plans?
2. In what school activities have you participated?
3. How do you spend your spare time? What are your hobbies?
4. In what type of position are you most interested?
5. Why do you think you might like to work at our company?
6. What jobs have you held? Why did you leave?
7. What course did you like best in school? Least? Why?
8. What do you know about our company?
9. Do you feel that you have received good general training?
10. Why do you feel that you will be successful in your field?
11. What extracurricular offices have you held?
12. What are your ideas on salary?
13. Do you prefer any specific geographic location? Why?
14. How much money do you expect to earn at the age of 20? 35?
15. How did you rank in school?
16. Do you think that your extracurricular activities were worth the time devoted to them?
17. What personal characteristics are necessary for success in your field?
18. What is your father's occupation?
19. Are you looking for a permanent or temporary job?
20. Do you prefer working alone or with others?
21. Can you take instructions without feeling upset?
22. Tell me a story.
23. Are you primarily interested in making money or do you feel that service to your fellowmen is satisfactory pay?
24. Do you live with your parents?
25. Can you get recommendations from previous employees?
26. What interests you about our products and services?
27. Do you feel you have done the best scholastic work of which you are capable?
28. How long do you expect to work?
29. Have you ever had any trouble getting along with fellow students?
30. Have you saved any money?

Information Sheet A-4b - (Continued)

31. Do you have any debts?

32. Do you attend a church?

33. Do you like routine work?

34. What size city do you prefer?

35. What is your major weakness?

36. Will you work hard to get ahead?

37. Are you eager to please?

38. What do you do to get in good physical condition?

39. Have you had serious illnesses or injuries?

40. Are you willing to relocate if the company wishes?

41. What job in the company would you like most to have?

42. Is it difficult for you to get along with people who have different backgrounds and interests than you?

43. Do you use liquor? How much?

44. Should an employer consider your grades? Why?

45. Would you be willing to work overtime? How much?

46. Do you posses any special skills or abilities?

47. What have you done that indicates initiative and a desire to work?

48. You have a complaint about your job or working condition. How would you handle it?

49. You and a fellow worker are having differences about your jobs. What would you do?

50. You have an idea you feel will help the company. What would you do?

*Courtesy of the Virginia Polytechnic Institute and State University Agriculture Education Department, Blacksburg, Virginia, in cooperation with the Agriculture Education Service, Division of Vocational Education - State Department of Education, Richmond, Virginia.

INFORMATION SHEET A-4c

THINGS TO REMEMBER AT THE INTERVIEW*

1. Sit up straight.
2. Speak in a quiet, pleasant voice.
3. Try to answer all questions correctly.
4. Never talk about personal problems.
5. Be respectful.
6. Use your best English at all times.
7. Know or write down the questions you wish to ask during the interview.
8. Never smoke or chew gum during the interview.
9. Inquire as to what follow-up procedure is required.
10. School subjects you liked best, extracurricular activities.
11. Your educational plans.
12. Ask some questions about the firm.
13. If you've ever been employed, be able to list employer, name of firm, date employed, address, salary and reason for leaving.

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*Courtesy of the Virginia Polytechnic Institute and State University, Agriculture Education Department, Blacksburg, Virginia, in cooperation with the Agriculture Education - State Department of Vocational Education, Richmond, Virginia.

INFORMATION SHEET A-4d

FACTORS WHICH FREQUENTLY LEAD TO REJECTION DURING THE JOB INTERVIEW

In the 1969 survey by Penn Tech Institute (Pittsburgh, Pennsylvania), the following factors were reported by 153 companies as having led to the rejection of the applicant during the employment interview.

1. Poor personal appearance.
2. Overbearing - overaggressive - conceited "superiority complex" - "know-it-all."
3. Inability to express himself clearly - poor voice, diction, grammar.
4. Lack of planning for career - no purpose and goals.
5. Lack of confidence and poise - nervousness - ill-at-ease.
6. Lack of interest and enthusiasm - passive, indifferent.
7. Failure to participate in activities.
8. Overemphasis on money - interested only in best dollar offer.
9. Poor scholastic record - just got by.
10. Unwilling to start at the bottom - expects too much too soon.
11. Makes excuses - evasiveness - hedges on unfavorable factors in record.
12. Lack of tact.
13. Lack of maturity.
14. Lack of courtesy, ill-tempered.
15. Condemnation of past employers.
16. Lack of social understanding.
17. Marked dislike for school work.
18. Lack of vitality.
19. Fails to look interviewer in eye.
20. Limpy, fishy hand-shake.
21. Indecision.
22. Loafs during vacations - lakeside pleasures.
23. Unhappy married life.
24. Friction with parents.
25. Sloppy application blank.
26. Merely shopping around.
27. Wants job only for short time.
28. Little sense of humor.
29. Lack of knowledge in field of specialization.
30. Parents make decisions for him.
31. No interest in company, or in industry.
32. Emphasis on whom he knows.
33. Unwillingness to go where we send him.
34. Cynical.
35. Low moral standards.
36. Lazy.
37. Intolerant - strong prejudices.
38. Narrow interests.
39. Spends too much time in movies.
40. Poor handling of personal finances.
41. No interest in community affairs.
42. Inability to take criticism.
43. Lack of appreciation of value of experience.
44. Radical ideas.
45. Late to interview without good reason.
46. Never heard of company.
47. Failure to express appreciation for interviewer's time.
48. Asks no questions about the job.
49. High pressure type.
50. Indefinite response to questions.

INFORMATION SHEET A-4e

CHECK LIST TO BE USED BEFORE GOING FOR AN INTERVIEW*

	Yes	No
1. Did I plan ahead for the interview?		
2. Am I nervous when I meet people?		
3. Do I ask intelligent questions?		
4. Do I become tense when asked questions?		
5. Am I highly emotional?		
6. Do I take pride in my appearance?		
7. Do I listen when someone else is talking?		
8. Do I look at the speaker?		
9. Do I practice good posture?		
10. Do I use proper English?		
11. Do I think before answering?		
12. Do I answer honestly?		

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*Check list courtesy of the Virginia Polytechnic Institute and State University, Agriculture Education Department, Blacksburg, Virginia, in cooperation with the Agriculture Education Service, Division of Vocational Education, State Department of Education, Richmond, Virginia.

UNIT B

HUMAN RELATIONS

Terminal Objectives

Upon completion of the modules in this unit, you will:

- Understand your personality and needs.
- Understand the principles involved in successful work attitudes.
- Be able to influence the behavior of others by successful use of motivating factors.
- Know the principles of law and ethics related to Allied Health workers.
- Adopt a personal code of ethics for your career as a health worker.

Student Competency Sheet

Unit B: HUMAN RELATIONS

Task 1: UNDERSTAND YOURSELF

Performance Checklist

1. Analyze yourself (interests, aptitudes, abilities, personality traits).
2. Analyze your needs (personal, financial).
3. Explore possible careers which will match your personal characteristics and your needs.
4. Set a career goal.
5. Establish short term goals that will help you reach your career goal.

Test

Items Needed:
1. Paper
2. Pen or pencil
3. Kimbrell and Vineyard, Succeeding in the World of Work (Bloomington, Ill: McKnight Publishing Co., 1975)
4. Allied Health Flow Chart (provided by your instructor)

Test:
1. Demonstrate that you understand yourself--your personality and needs.
2. Demonstrate that you can relate knowledge of yourself to career plans.

Standard:
1. Your evaluation of your personality traits, as shown by you on the "Personality Rating Sheet" (Information Sheet B-1) will include a plan to improve any traits rated as "Fair," "Poor," or "Very Poor."
2. You will correctly answer 10 of the 12 questions on the test for this task.

Learning Activities:

1. Read pages 81-94, Succeeding in the World of Work.
   a. Make a vocabulary list of new words.
   b. Learn what these words mean.
   c. Discuss the meaning of the words with several classmates.

2. Rate your own personality, using the "Personality Rating Sheet" (Information Sheet B-1).
   a. List your personality traits which need improvement (anything not rated as "Good" or "Excellent"). Try to be honest and objective. (Most of us can use some improvement.)
   b. You may discuss your goals with your instructor to get helpful suggestions for improvement of personality traits which may affect your career plans.
   c. Write your plan for improving any areas not rated as "Good" or "Excellent."
   d. Obtain an envelope from your instructor. Place your evaluation in the envelope. It will be placed in your folder. At the end of the semester, get this envelope and rate yourself again. Note the improvements.

3. See and participate in the following units of Job Survival Skills Program:
   a. Unit I, "Introduction"
   b. Unit II, "Education and Training"
   c. Unit IV, "Self-Concept and Employment"

4. Read pages 95-96, Succeeding in the World of Work. Write a separate paper on each of the following words. Tell what the words mean to you and your personality.
   a. Parental pressure, teacher pressure, and peer pressure
   b. Economic resources
   c. Marital status
   d. Chance
   e. Self-concept

5. Submit each of the above papers to your instructor. Discuss them with the instructor.

6. With the help of your instructor and classmates, review the "Allied Health Flow Chart."
   a. Identify the job area for which you are probably best suited.
   b. List areas of your personality you will need to develop in order to perform your chosen job.
   c. Discuss with your instructor and classmates how these personality factors (traits) are important in performing the skills of your chosen job.

7. Use the job area or areas you listed in Activity 6 as your "dream" statement.
   a. Discuss your "dream" paper with your instructor. Explore your personal needs and the requirements of the job area you have identified.
   b. Discuss what you can do to fullfill (1) these needs and (2) requirements of the job you would like to have.

8. Take the written test for this task. You may not use references.

INFORMATION SHEET B-1

SELF-RATING YOUR PERSONALITY

Rate your own personality according to traits which make up your personality. Use the chart below:

PERSONALITY RATING

Trait	Excellent	Good	Fair	Poor	Very Poor
ATTITUDE					
COURTESY					
DEPENDABILITY					
DESIRE TO SUCCEED					
ENTHUSIASM					
FORESIGHT					
FRIENDLINESS					
HEALTH					
HONESTY					
INITIATIVE					
LOYALTY					
MORALITY					
NEATNESS					
OPEN-MINDEDNESS					
PERSONAL APPEARANCE					
PUNCTUALITY					
SELF CONTROL					
SENSE OF HUMOR					
TACT					
USE OF VOICE					

Student Competency Sheet

Unit B: HUMAN RELATIONS

Task 2: UNDERSTAND SUCCESSFUL WORK ATTITUDES

Performance Checklist

1. Identify personal traits that affect your relationship with others.
2. Analyze how personal traits and attitudes of others affect you.
3. Analyze how your personal traits affect others.
4. Identify and analyze the ways the attitudes of others are influenced by your attitudes, traits and habits.
5. Make a plan to upgrade your attitudes, traits and habits.

Test

Items Needed:
1. Paper
2. Pencil or pen
3. Envelope

Task: Demonstrate your understanding of the principles involved in "successful work attitudes."

Standard:
1. Your instructor will evaluate your role-play performance of positive and negative attitudes. Your performance must show that you understand:
    a. Yourself in a given role.
    b. How your attitude reflects on your relationship with co-workers.
    c. How your attitude reflects on your relationship with your supervisors.
    d. How your attitude reflects on your relationship and effectiveness with patients.
2. On the test for this task, you must answer 12 of the 15 questions correctly.

Learning Activities

1. Read pages 50-61, Succeeding in the World of Work.
    a. List and define new terms.
    b. Discuss these terms and what they mean to you with your classmates.

2. Take the "5-Minute Timed Test on Following Directions." (Your instructor will supply the test.)
    a. Remember the terms "honesty" and "discipline": do not "clue" another student as to the content of this test.

3. Read and complete Information Sheet B-2, "Personality Rating."
    a. Put your completed rating sheet in an envelope and seal the envelope.
    b. Give the envelope to your instructor to keep until you have completed the activities for this task.

4. See and participate in the following units of Job Survival Skills Program:
   a. Unit VI, "You and Your Supervisor"
   b. Unit VII, "You and Your Co-Workers"
   c. Unit VIII, "Successful Job Behavior"

5. Participate in a class discussion on positive and negative attitudes as related to the Allied Health worker:
   a. Role-play attitudes which have been identified by the group.
   b. How have the attitudes demonstrated in the role-play situation changed when the actors played the role of a child? an adult? an elderly person? a handicapped person? a terminally ill patient?
   c. Your instructor will evaluate your performance.

6. Take the written evaluation for this task. You must answer 12 of the 15 questions correctly.

7. Your instructor will return the envelope which contains your self-rated "Personality Rating."
   a. Review your self-ratings. Rate yourself again. Have the ratings changed?
   b. Discuss with your instructor the ways you can improve your personality traits to be a more effective Allied Health worker.

INFORMATION SHEET B-2

UNDERSTAND SUCCESSFUL WORK ATTITUDES

You have read about and discussed traits which make up personality and affect your relationship with others. These traits are very important to Allied Health workers. Rate your own personality according to the chart below:

PERSONALITY RATING

Trait	Excellent	Good	Fair	Poor	Very Poor
ATTITUDE					
COURTESY					
DEPENDABILITY					
DESIRE TO SUCCEED					
ENTHUSIASM					
FORESIGHT					
FRIENDLINESS					
HEALTH					
HONESTY					
INITIATIVE					
LOYALTY					
MORALITY					
NEATNESS					
OPEN-MINDEDNESS					
PERSONAL APPEARANCE					
PUNCTUALITY					
SELF CONTROL					
SENSE OF HUMOR					
TACT					
USE OF VOICE					

Student Competency Sheet

Unit B: HUMAN RELATIONS

Task 3: USE PRINCIPLES OF HUMAN RELATIONS

Performance Checklist

1. Make a list of things others do or attitudes they have that annoy you or that you find difficult to deal with.
2. Make a list of things you do or attitudes you may have that might annoy others or make others feel you are difficult to deal with.
3. Make a list of things you find pleasant in others.
4. Make a list of things others have found pleasant in you.
5. Review these lists to identify positive things about yourself that can influence others.
6. Analyze how the things you listed in #5 can affect your career goal.

Test

Items Needed:
1. Paper
2. Pen or pencil
3. Partner

Task: Demonstrate your understanding of
- a. Some of the motivating factors which cause human beings to behave as they do, and
- b. Ways of influencing others to behave as you would like them to behave.

Standard:
1. Your instructor will evaluate your written and performance demonstrations of how well you understand and can cope with factors which motivate the way people behave.
2. Your instructor will evaluate the written test for this task. You must answer 12 of the 15 questions correctly.

Learning Activities

1. Read pages 104-111, Succeeding in the World of Work.
   - a. List and define new terms.
   - b. Discuss these terms and what they mean to you with your classmates.

2. See and participate in the following units of Job Survival Skills Program:
   - a. Unit III, "From Which Point of View"
   - b. Unit V, "Communication"
   - c. Unit XIV, "Summarizing"
   - d. Unit XV, "Individual Assessment"

3. Write a paragraph discussing why human relations are important to your career. Have your instructor evaluate your work.

4. With a fellow student, role-play a situation between a practical nursing student and a patient or hospital employee.
   - a. Have your instructor evaluate your behavior during the performance.
   - b. Have your classmates discuss their reactions to your performance.

5. Using the same student partner as in Learning Activity 4, describe in writing what message this person's body language conveyed to you during your demonstration.
    a. Discuss your findings with your partner.
    b. Re-play the situation and discuss improvements.

6. While you are in clinical practice sessions at the patient facility, your instructor will evaluate your progress. Look at the "Performance Appraisal" example (Information Sheet B-3). Each area of your performance is appraised: skill, competence and personal effectiveness (how your actions affect others).
    a. Discuss with your classmates how you can strive to achieve personality performance skills that will help you earn the best ratings for each item on the form.

7. Take the written evaluation for this task. You must answer 12 of the 15 questions correctly. (You may not use references.)

INFORMATION SHEET B-3

PERFORMANCE APPRAISAL
(For Allied Health Personnel)

Name: Hospital: Department:

School: Date of Work:

INSTRUCTIONS: This form should be used to evaluate employee performance. It should be reviewed with the employee. Place a check in the space which best expresses your judgment.

1.	QUALITY OF WORK	Unsatisfactory ( )	Satisfactory ( )	Above Average ( )
2.	QUANTITY OF WORK	Substandard ( )	Average ( )	High ( )
3.	POTENTIAL	Doubtful ( )	Promising ( )	Above Average ( )
4.	ATTITUDE	Indifferent ( )	Normal Interest ( )	Enthusiastic ( )
5.	COOPERATION WITH OTHERS	Antagonistic ( )	Satisfactory ( )	Supportive ( )
6.	JOB SKILL	Low ( )	Adequate ( )	Good ( )
7.	INITIATIVE	Needs Prodding ( )	Does Assigned Work Well ( )	Seeks Tasks to be done ( )
8.	ATTENDANCE	Unsatisfactory ( )	Satisfactory ( )	No. of days Present ( )
9.	APPEARANCE	Must Improve ( )	Satisfactory ( )	Outstanding ( )

COMMENTS____

____

____

____

SIGNATURE OF IMMEDIATE SUPERVISOR____________________DATE__________

SIGNATURE OF EMPLOYEE RATED________________________DATE__________

Student Competency Sheet

Unit B: HUMAN RELATIONS

Task 4: PRINCIPLES OF LAW AND ETHICS

Performance Checklist

1. Locate and learn laws, codes of ethics and "bills of rights" as related to Allied Health workers.
2. Determine the differences between "laws" and "ethics."
3. Determine any differences between the "rights" of a patient and the "rights" of an Allied Health worker.
4. Develop and defend a personal code of ethics for yourself as an Allied Health worker.
5. Develop a code of ethics for your class.

Test

Items Needed:	1. Paper 2. Pen or pencil
Task:	Demonstrate your understanding of the principles of law and ethics as they are related to the Allied Health workers.
Standard:	1. Your instructor will evaluate your contributions to the class-developed code of ethics. 2. On the test for this task, you must answer 14 of the 20 questions correctly.

Learning Activities

1. Read pages 1-6, Nursing Skills for Allied Health Services, Vol. I (1st and 2nd Editions).
   a. Start a vocabulary list for your notebook, as stated on pages 1 and 2.
   b. Discuss new terms and what they mean to you with your classmates and instructor.

2. Read pages 10-19, Nursing Skills for Allied Health Services, Vol. I, 2nd Ed. (pp. 11-19, 1st ed.).

3. Attend a lecture by your instructor on law and ethics in Allied Health, as they apply to the student practitioner. The discussion will include:
   a. Patients' Bill of Rights
   b. Law governing biological transport of goods.
   c. Discuss these items with your class.

4. Discuss "The Code of Ethics for the L.P.N." and the International Code of Nursing Ethics." (These were contained in the readings of Activity 3.) How do they apply to your occupational area?

5. Work with your class, under the supervision of your instructor, to compose a code of ethics for Licensed Practical Nurse. This code will guide you in your professional activities.
   a. First, write your own code of ethics.
   b. Ask your instructor for further activities if you feel insecure in your understanding of law and ethical behavior as related to Licensed Practical Nurses.
   c. Work with your class and your instructor to develop a Code of Ethics for your class project.

6. Take the written evaluation for this task. You must answer 14 of the 20 questions correctly. You may not use references.

UNIT C

CHARTING, REPORTING AND RECORDING

Terminal Objectives

Upon completion of the modules in this unit, you will:

- Know the meanings of simple terms used in medical terminology.
- Be familiar with charting forms, processes and uses.
- Be able to chart patient information correctly.

Student Competency Sheet

Unit C: CHARTING, REPORTING AND RECORDING

Task 1: USE SIMPLE MEDICAL TERMINOLOGY

Performance Checklist

1. Learn the uses of a patient chart/report.
2. Identify information required on a patient chart/report.
3. Learn the terminology and abbreviations used on a patient chart/report.
4. Learn the terms and abbreviations used to record patient observations.

Test

Items needed:
1. Patient observation report
2. Patient record
3. Patient chart
4. Patient record form
5. Patient chart form
6. Vocabulary list notebook
7. Paper
8. Pen

Task: Use clear, concise terms or abbreviations to plainly describe a situation pertaining to a patient.

Standard: Answer 16 of 20 written questions accurately. You may not use references.

Learning Activities

1. Read pages 377-381, The Nurse Aide and/or pages 361-384, Nursing Skills for Allied Health Services, Vol. I, 2nd Ed. (pages 103-117, Vol. I, 1st Ed.).

2. Review the patient chart sheets provided by your instructor.

3. Attend a class discussion directed by the instructor on forms and methods for charting.

4. Review Information Sheet C-1, "Commonly Used Abbreviations." You may be familiar with many of the terms. All of the terms listed are commonly used. Learn them so that you can read your work assignments efficiently and chart your notations on patient charts. To learn the terms:
   a. Review them
   b. Use them in conversation with you classmates.

5. View Trainex film "Observation and Charting"
   a. Take notes of the charting procedure discussed.
   b. Discuss anything unclear to you with your instructor.
   c. Practice the pronunciation of new vocabulary words.

6. Complete the Self-Check Test C-1. Do not use references.

7. Review the entries in your vocabulary list notebook. Notice how many new terms you have already learned. Each set of occupations has its own language. To work in the field of medicine, you must build your vocabulary and use it as an important tool in your career. Review the terms often.

8. Complete information Sheet C-1a. You may use pages 381-382, Nursing Skills for Allied Health Services, Vol. I, 2nd Ed. (pages 106-116, Vol. I, 1st Ed.)
   a. Have your instructor evaluate your work.

9. Complete Self-Check Test C-1a.
   a. Check your answers with the teacher's "Answer Sheet."
   b. Discuss your results with your instructor.

10. Write a paper (50 words or less) which states:
    a. The necessity of keeping patient records or charts.
    b. The need to store patient records and charts in a systematic order from admission to discharge.

11. Discuss your paper with another student. Have your instructor evaluate your work.

Adapted from:
Allied Health Program, Boone County Career and Technical Center,
Danville, WV

INFORMATION SHEET
C-1

COMMONLY USED ABBREVIATIONS

abd.	abdomen
ad. lib.	as needed
A.M.	morning
amb.	ambulatory, walking
ax	axillary (armpit)
bid	twice per day
B.M.	bowel movement
B.P.	blood pressure
B.R.P.	bathroom privileges
$\bar{c}$	with
ca	cancer
cc (c.c.)	cubic centimeters
c/o	complains of pain
DC	discontinue
ECG (EKG)	electrocardiogram
E.R.	emergency room
G.I.	gastrointestinal (stomach and intestine)
G.U.	genitourinary
h.	hour
Hgb.	hemoglobin
H_2O	water
h.s.	bedtime
I and O	intake and output
IV	intravenous (within vein)
lab.	laboratory
L.L.Q.	left lower quadrant
L.U.Q.	left upper quadrant
med.	medical (or medication)
noc	night
NPO	nothing by mouth
O_2	oxygen
O.B.	obstetrics
O.R.	operating room
oz.	ounce
p.	pulse
Ped. or Peds.	pediatrics
per	by or through
p.o.	by mouth
post-op	after surgery
p.r.n.	when necessary
psych.	psychology
P.T.	physical therapist
q.h.	every hour
q.s.	quantity sufficient
r or resp.	respirations
s.s.	soapsuds
sse	soapsuds enema
stat	at once
staph	staphylococcus (germ)
T.P.R.	temperature, pulse, respiration
V.D.	venereal disease
via	by way of
wt.	weight

SELF CHECK TEST
C-1

COMMONLY USED ABBREVIATIONS

Write out the proper name for these corresponding abbreviations.

1. abd.
2. ad.lib.
3. A.M.
4. amb.
5. ax
6. bid
7. B.M.
8. B.P.
9. B.R.P.
10. $\bar{c}$
11. ca
12. cc (c.c.)
13. c/o
14. DC
15. ECG (EKG)
16. E.R.
17. G.I.
18. G.U.
19. h.
20. Hgb.
21. H_2O
22. h.s.
23. I and O
24. lab.
26. L.L.Q.
27. L.U.Q.
28. med.
29. noc
30. NPO
31. O_2
32. O.B.
33. O.R.
34. oz.
35. p.
36. Ped. or Peds
37. per
38. p.o.
39. post-op
40. p.r.n.
41. psych.
42. P.T.
43. q.h.
44. q.s.
45. r or resp.
46. s.s.
47. sse
48. stat
49. staph
50. T.P.R.
51. V.D.
52. via
53. wt.

INFORMATION SHEET
C-1a

DESCRIPTIVE TERMS

Define these descriptive terms. You may use references.

1. ecchymotic
2. profuse
3. scanty
4. obese
5. acutely ill
6. anxious
7. cyanotic
8. jaundiced
9. hearty appetite
10. poor appetite
11. edema
12. cheerful
13. gluteal area
14. burping, eructating
15. dyspnea
16. apnea
17. deformed
18. tarry B.M.
19. clay colored B.M.
20. coma
21. alert
22. formed stool
23. liquid stool
24. mucoid
25. stool
26. purulent drainage
27. emesis
28. pale skin
29. flushed skin
30. clubbed fingers
31. flatus
32. atrophy
33. dentures
34. to prevent
35. pass fluid from bladder
36. unable to control

SELF-CHECK TEST
C-1a

DESCRIPTIVE TERMS

Define these descriptive terms.

1. ecchymotic
2. profuse
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28. pale skin
29. flushed skin
30. clubbed fingers
31. flatus
32. atrophy
33. dentures
34. to prevent
35. pass fluid from bladder
36. unable to control

Student Competency Sheet

Unit C: CHARTING, REPORTING AND RECORDING

Task 2: RECORD PATIENT INFORMATION IN CHART FORM

Performance Checklist

1. Write a patient observation report.
2. Complete a patient record.
3. Complete a patient chart.

Test

Items needed:
1. Chart forms
2. Kardex cards
3. Paper
4. Pencil and paper
5. Patient information
6. Information on patient treatment procedures or observations and progress, written in lay terms.

Task: Use chart form to report patient information.

Standard: You will be rated according to a previously constructed form of the information:
a. You may not use references.
b. Your recording must be 90 percent accurate.

Learning Activities

1. View Trainex film, "Observation and Charting."
   a. Take notes.
   b. Discuss the film with your instructor.

2. Read pages 381-386, The Nurse Aide and/or pages 385-386, Nursing Skills for Allied Health Services, Vol. I, 2nd Ed. (pages 99-103 and 119-122, Vol. I, 1st Ed.).

3. Review kardex cards. (The patient chart is confidential information.)
   a. Participate in a class discussion on kardex cards.
   b. Participate in a class discussion on chart forms.

4. Review the list of things that must be reported. Also list those things you feel are necessary to report to the instructor while you are receiving practice in the clinical area of a hospital.

5. Attend a class discussion on charting and reporting and how it applies to you as a student.

6. Obtain chart forms from your instructor and complete them according to the instructor's directions.

7. Using Examples 1 and 2 from Self-Check Test C-2:
   a. Complete the headings on chart forms.
   b. Enter the information in the proper form for patient charting.
   c. Check your work with the teacher's "Answer Sheet."
   d. Discuss any discrepancies with your instructor.

Adapted from:
Allied Health Program, Boone County Career and Technical Center,
Danville, WV

SELF-CHECK TEST
C-2

CHARTING

Example 1:

12 noon put in room 101

Mrs. John Doe was admitted to the hospital walking with her husband. She said she had a pain in her left foot. The usual admitting procedures were done and the results of the recordings are: temperature 98.6 oral, pulse 64, respirations and blood pressure - 120/70 20 per minute. She has a skin condition that makes her look red. While in bed, she was served a general diet tray and she ate all of it. She walked around the hospital hallway and visited with the other patients. When questioned, she said she felt good.

Example 2:

Chart form the following information:

Jim Jones was admitted from the emergency room to have an operation today. He was taken to room 200 to prepare him for surgery. The procedures are as follows:

Temperature 99.2 taken rectally
Pulse 104 good beat
Respirations 24
Blood pressure systolic 100 diastolic 70

His abdominal skin was shaved and scrubbed with soap. A soapsuds enema was given and the results of this procedure was return of a bowel movement which looked like clay and was colored grey; he also passed a lot of gas. He put on a patient gown and took out his false teeth and put them in a cup; he fell asleep and slept until the orderly came to the room to take the patient to surgery on a gurney.

UNIT I

MAINTAINING A CLEAN, SAFE ENVIRONMENT

Terminal Objectives

Upon completion of the modules in this unit, you will:

- Use correct technique for washing your hands and for cleaning instruments and supplies.
- Operate the controls of the hospital bed in order to adjust the bed position as may be required.
- Prepare an unoccupied, occupied, and surgical hospital bed in a way that is safe and comfortable for the patient.
- Assist with or give range of motion exercises and assist the patient to turn, cough and deep-breathe.
- Position the patient.
- Employ proper body mechanics in the performance of all of the above skills.

Student Competency Sheet

Unit I: MAINTAINING A CLEAN, SAFE ENVIRONMENT

Module A: Personal Preparation

Task 1: WASH HANDS

Performance Checklist

1. Stand in a comfortable position in front of the sink.
2. Adjust water flow and temperature. NOTE: If faucets are hand operated, use paper towel to turn on and off.
3. Wet hands thoroughly.
4. Apply soap.
5. Wash hands.
   a. Use circular motion.
   b. Include palms, wrists, back of hands and fingers of each hand.
   c. Wash approximately thirty (30) seconds.
6. Rinse well. Allow water to run from wrists to fingertips.
7. Repeat steps 3-6.
8. Dry hands gently.
9. Turn off water. NOTE: If faucets are hand operated, use paper towel to turn on and off.
10. Apply lotion, if desired.

Test

Items Needed:
1. Washing facilities
2. Paper towels
3. Soap
4. Lotion

Task: Wash your hands

Standard:
1. The hand washing procedure will be evaluated by your instructor in accordance with a performance checksheet.
2. All checksheet items must be rated "acceptable".

Learning Activities

1. Read pages 123-138, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp.36-46, 2nd Ed.)

2. Read pages 3-1 to 3-17, Being a Nursing Aide, 1st Ed. (pp. 39-50, 2nd Ed.).

3. Watch the Trainex filmstrip, "Medical Asepsis".

4. Watch the demonstration by the instructor.

5. Practice the procedure.

6. Perform a return demonstration for the instructor or a fellow student.

7. Complete the performance check for this task.

Name___________________________
Date___________________________
Unit I, Module A, Task 1

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Stood away from sink to avoid contacting sink with clothing.		
2. Adjusted water volume and temperature.		
3. Wet hands.		
4. Applied soap thoroughly.		
5. Washed palms and backs of hands with strong friction.		
6. Washed fingers, between fingers, wrists, and lower forearms.		
7. Rinsed well. Allowed water to run from wrists to fingers.		
8. Repeated steps 4-7.		
9. Dried thoroughly with paper towel from wrists to fingertips.		
10. Turned off water with paper towel.		
11. Discarded towel in receptacle.		

Student Competency Sheet

Unit I: MAINTAINING A CLEAN, SAFE ENVIRONMENT

Module B: Unit Equipment Care

Task 1: CLEAN INSTRUMENTS AND SUPPLIES

Performance Checklist

1. Open any clamps.
2. Rinse with cool water, forcing water through such items as tubing, syringes and needles.
3. Soak in soap or detergent.
4. Scrub with brush, especially in grooves and indentations.
5. Rinse under running water.
6. Dry by hand or force-air dry, where appropriate.
7. Place damaged or broken instruments in appropriate containers for repair or discarding.
8. Prepare articles for sterilization with appropriate solution.

Test

Items Needed: 1. Instruments (supplied by instructor)
2. Supplies (supplied by instructor)

Task: Wash and dry the instruments and supplies.

Standard: All items must be washed and dried in the proper manner.

Learning Activities

1. Read Chapter 3, Being a Nursing Aide, 1st Ed. or 2nd Ed.

2. Practice cleaning equipment and supplies as provided by instructor.

3. Demonstrate proper cleaning techniques and have a fellow student critique your demonstration.

4. Visit a Hospital Central Supply Service Area.

5. List and describe methods of cleaning equipment and supplies observed in the Central Supply Service.

6. Define medical asepsis. Define surgical asepsis. Differentiate between the two.

7. Discuss, in small groups, the role of nursing personnel in cleaning equipment and supplies for return to a Central Supply Service.

Student Competency Sheet

Unit I: MAINTAINING A CLEAN, SAFE ENVIRONMENT

Module C: Body Mechanics

Task 1: OBSERVE BODY MECHANICS AND SAFETY MEASURES

Performance Checklist

Stooping

1. Feet apart, one foot slightly advanced.
2. Position to provide stable base of support.
3. Lower body to stooped position; back and trunk straight; knee and hip joints flexed.
4. Shift weight to advanced foot and ball of rear foot.
5. Raise the body to a standing position: back kept straight; move initiated by extending hip and knee joints.

Reaching

1. Start with a stable base of support.
2. Start movement with body in good alignment and balance.
3. Check distance to be reached in order to obtain object. Obtain footstool or ladder for use if necessary.
4. Utilize footstool appropriately: line of gravity centered over center of footstool; feet in balanced postition.
5. Reach up from a position directly in front of the object.
6. Lift the object from the shelf using good alignment procedures
7. Lower the object with smooth, coordinated movement.
8. Lower yourself from the ladder or footstool, if required, using principles of body alignment.
9. Place the object on a shelf of working height or stoop and lower it to the floor observing good principles of body alignment.

Pivoting

1. Stand with feet slightly apart, knees slightly flexed.
2. Set trunk and pelvic muscles for action.
3. Set thigh and leg muscles.
4. Shift weight to ball of each foot.
5. Pivot or make 90 degree turn on feet. (Body moves simultaneously with feet so that there is no twisting of lower back.)
6. Distribute weight equally on each foot following turn.

Lifting and Carrying

1. Start with a stable base.
2. Demonstrate proper body alignment.
3. Grasp a box of books (or other object) in its center of gravity.
4. Set abdominal and arm muscles for action; lift box of books; bring it close to own line of gravity.
5. Carry box near midline of body for a period of approximately five (5) minutes.

6. Shift box from side to side as required during period of support.
7. Place box on counter or chair for short periods of time during which you may observe rest period.
8. Return box of books to storage area.

Pushing and Pulling

1. Start action with stable base of support.
2. Position observing principles of body alignment and keeping body erect (feet at least eight (8) inches apart with one foot slightly advanced).
3. Set trunk and leg muscles.
4. Lean toward stretcher in order to push. Observe principles of good body alignment during this action, keeping back straight and erect.
5. Lean away from stretcher in order to pull. Observe principles of good body alignment during this action, keeping back straight and erect.
6. Return equipment to storage area.

Test

Items Needed:	1. Ladder or footstool 2. Box of books 3. Stretcher with heavy object on it
Task:	Performance of good body mechanics using safety measures in stooping, reaching, pivoting, lifting and carrying, and pushing and pulling.
Standard:	1. The student's body must be kept in good body alignment using the correct muscles for each movement. 2. The written exam must be completed with 85% accuracy.

Learning Activities

1. Read pages 53-98, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 59-81, 2nd Ed.); and pages 4-7 to 4-12, Being a Nursing Aide, 1st Ed. (pp. 89-94, 2nd Ed.).

2. Observe a demonstration by your instructor.

3. In small groups, demonstrate for fellow students one of the five movements listed.

4. Practice all of the movements.

5. As available, watch any of the following filmstrips/films:

   a. "Body Mechanics" - Trainex
   b. "A New Way to Lift" - C & P Telephone
   c. "To Fall or Not to Fall" - C & P Telephone
   d. "Facts About Backs" - West Virginia State Department of Health
   e. "I Am Joe's Back" - West Virginia State Department of Health (a Readers' Digest film)
   f. "The Muscular System" - West Virginia State Department of Health
   g. "The Skeletal System" - West Virginia State Department of Health

6. Discuss, in small groups, the films/filmstrips available to your class.

7. Perform return demonstrations for your instructor or fellow student for two (2) of the five (5) movements.

8. Diagram proper body mechanics for all five (5) movements, using simple stick figures. Keep these in your notebook for future reference.

9. Complete the written test for this task.

Student Competency Sheet

Unit I: MAINTAINING A CLEAN, SAFE ENVIRONMENT

Module C: Body Mechanics

Task 2: POSITION PATIENT IN BED

Performance Checklist

1. Side-lying or lateral position
   - a. Wash hands.
   - b. Identify patient and explain procedure.
   - c. Adjust bed.
   - d. Lower siderail on near side.
   - e. Prepare the patient for movement.
   - f. Place patient in side-lying (lateral) position.
   - g. Align patient's body in good position.
   - h. Flex patient's upper leg so it does not rest on lower leg.
   - i. Position patient's lower arm to rear of patient.
   - j. Support body in good alignment.
   - k. Use artificial aids to reduce pressure, if necessary.
   - l. Raise and lock siderail.
   - m. Record procedure.

2. Prone position
   - a. Wash hands.
   - b. Identify patient and explain procedure.
   - c. Adjust bed.
   - d. Lower siderail on near side.
   - e. Prepare patient for movement.
   - f. Turn patient.
     - (1) Place one hand on proximal shoulder.
     - (2) Place one hand on hip.
     - (3) Roll patient's body toward you.
   - g. Adjust patient's body alignment.
   - h. Use artificial aids to reduce pressure, if necessary.
   - i. Raise and lock siderails.
   - j. Record procedure.

3. Horizontal Recumbent (Supine) position
   - a. Wash hands.
   - b. Identify patient and explain procedure.
   - c. Adjust bed.
   - d. Lower siderail on near side.
   - e. Prepare patient for movement.
   - f. Place patient in a Horizontal Recumbent position.
     - (1) Roll patient to his/her back.
     - (2) Place pillow under patient's head.
     - (3) Extend legs.
   - g. Adjust patient's body alignment.
   - h. Support body parts, as necessary.
   - i. Use artificial aids to release pressure on bony prominences, if necessary.
   - j. Raise and lock siderails.
   - k. Record procedure.

Test

Items needed:
1. Patient who is unable to turn herself/himself
2. Bed with siderails
3. Pillow
4. Artificial aids

Task:
1. Position the patient in the Lateral, or side-lying position.
2. Position the patient in the Prone position.
3. Position the patient in the Horizontal Recumbent (Supine) position.

Standard: The patient's body alignment must be maintained and supported.

Learning Activities

1. Read pages 311-341, Nursing Skills for Allied Health Services, Vol. I, 1st ed. (pp. 101-104, 111-112, 113-115, and 118-122, 2nd ed.).
2. Read pages 6-7, Being a Nursing Aide, 1st ed. (pp. 279-283, 2nd ed.).
3. Watch demonstration by the instructor.
4. Practice the positions and perform a return demonstration.
5. Watch Trainex filmstrip, "Positioning to Prevent Contractures" and/or film loop series "Prevention of Footdrop," Parts I and II.
6. Discuss the reasons for positioning the patient in bed.
7. List supportive aids to help the patient maintain good body alignment while in bed.
8. Take written evaluation. Your answers must be 85% accurate.

Student Competency Sheet

Unit I: MAINTAINING A CLEAN, SAFE ENVIRONMENT

Module C: Body Mechanics

Task 3: ASSIST WITH OR GIVE RANGE OF MOTION EXERCISES

Performance Checklist

1. Wash hands.
2. Identify patient and explain procedure.
3. Position patient.
4. Flex, extend, and rotate the neck and lateral flexion.
5. Take shoulder joint through flexion, extension, internal rotation, and external rotation.
6. Take the wrist through flexion, extension, supination, and pronation and lateral flexion.
7. Flex, extend, abduct, and adduct fingers.
8. Flex, extend, abduct, and adduct hip and knee joints.
9. Rotate hip internally and externally.
10. Flex and hyperextend the ankle.
11. Rotate ankle inwardly and outwardly.
12. Flex, extend, abduct and adduct toes.
13. Leave patient comfortable.
14. Report procedure and observations.

Test

Items Needed: Patient who is unable to move one or more joints.

Task:
1. Take the affected joints through a range of motion exercises.
2. Instruct the patient in range of motion of unaffected joints.

Standard:
1. The affected extremity must be supported.
2. The joints must be moved without causing pain.

Learning Activities

1. Read pages 249-260, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 130-141, 2nd Ed.).

2. Observe the demonstration by the instructor.

3. Perform a return demonstration for your instructor or a fellow student.

4. Watch the Trainex filmstrip, "Range of Motion Exercises to Prevent Contractures,"

5. Practice the exercises and perform another return demonstration.

6. Discuss in small groups, or with a fellow student, the body mechanics of the six joint movements.

7. Define passive and active exercise.

8. Take the written evaluation. Your answers must be 85% accurate.

Student Competency Sheet

Unit I: MAINTAINING A CLEAN, SAFE ENVIRONMENT

Module C: Body Mechanics

Task 4: ASSIST PATIENT TO TURN, COUGH AND DEEP BREATHE

Performance Checklist

1. Identify patient.
2. Explain procedure
3. Place patient in supine position with head elevated as high as condition will permit.
4. Instruct patient to take a deep breath and cough as forcibly as possible.
5. Support operative site if appropriate.
6. Repeat steps 4 and 5 three (3) to five (5) times.
7. Change patient's position at least every two hours.
   a. Ask patient to turn if patient is able.
   b. Turn patient if patient is unable to turn own body, using good body mechanics and providing for the safety of the patient.
8. Report observations.

Test

Items Needed:
1. Patient
2. Bed

Task:
1. Assist a patient to turn.
2. Assist a patient to cough.
3. Assist a patient to deep breathe.

Standard:
1. Patient's position must be changed.
2. Patient must cough and take deep breath.
3. The procedure will be evaluated by your instructor using the performance checksheet. All checksheet items must be rated "acceptable."

Learning Activities

1. Read page 724, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. or Being A Nursing Aide, 2nd Ed. page 337.

2. Observe the demonstration by your instructor.

3. Practice the procedure with a fellow student.

4. Role play a situation of teaching and assisting a post-operative patient to cough and deep breathe. Alternate roles of patient and nursing personnel.

5. Practice reporting and recording your observations following the role-play situations.

6. Complete the performance checksheet for this task.

Name__________________________
Date__________________________
Unit I, Module C, Task 4

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Identify patient.		
2. Explain procedure		
3. Place patient in supine position with head elevated as high as condition will permit.		
4. Instruct patient to cough and deep breathe. Demonstrate if necessary.		
5. Support operative site if appropriate.		
6. Repeat steps 4 and 5 three (3) to five (5) times		
7. Change patient's position at least every two hours		
8. Report observations.		

Student Competency Sheet

Unit I: MAINTAINING A CLEAN, SAFE ENVIRONMENT

Module D: Bed Preparation and Adjustment

Task 1: ADJUST THE HOSPITAL BED

Performance Checklist

1. Fowler's Position
   - . Elevate head of bed 45° to 60°.
2. Semi-Fowler's Position
   - . Elevate head of bed 45°.
   - . Raise knees 15°.
3. Jack-Knife or William's Position
   - . Elevate head of bed approximately 35° - 40°.
   - . Raise foot of bed approximately 30°. (Thighs should be at right angles with the abdomen.)
4. Trendelenburg Position (See Note)
   - . Lower head of bed to horizontal position.
   - . Elevate foot of bed 20° - 30° higher than head.
5. Reverse Trendelenburg Position (See Note)
   - . Lower foot of bed to horizontal position.
   - . Elevate head of bed 20° - 30° higher than feet.

NOTE: The mid-section of the bed should be adjusted so the patient is lying straight.

Test

Items Needed: Manually operated hospital bed and patient

Task: Adjust the bed to the following positions:
1. Fowler's
2. Semi-Fowler's
3. Jack-Knife or William's
4. Trendelenburg
5. Reverse Trendelenburg

Standard:
1. All bed adjustments listed must be performed without errors in selection.
2. All bed adjustments must be performed without errors in accordance with performance checklist.

Learning Activities

1. Observe a demonstration by your instructor.
2. Practice the positions with a fellow student as the patient.
3. Read pages 139-144, Nursing Skills for Allied Health Services, Vol. I, 1st ed. (pp. 112, 115-118 and 191-198, 2nd ed.).
4. Practice the positions again and record the effects on the "patients".
5. Complete the performance checklist under the supervision of the instructor.

Name_____________________________
Date_____________________________
Unit I, Module D, Task 1

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Fowler's Position		
2. Semi-Fowler's Position		
3. Jack-Knife or William's Position		
4. Trendelenburg Position		
5. Reverse Trendelenburg Position		

Student Competency Sheet

Unit I: MAINTAINING A CLEAN, SAFE ENVIRONMENT

Module D: Bed Preparation and Adjustment

Task 2: ADJUST SIDERAILS FOR PATIENT SAFETY

Performance Checklist

1. Explain to patient and family that siderails are used for the patient's safety.
2. Raise siderails to "up" and "locked" position.
3. Provide for patient's comfort.
4. Attach signal cord within patient's reach.
5. Instruct patient to call for assistance when needed.
6. Record procedure.

Test

Items Needed:
1. Patient
2. Hospital bed with siderails attached
3. Signal cord

Task: Adjust the siderails to the "up" and "locked" positions.

Standard: Rails will be securely locked.

Learning Activities

1. Read pages 139-142, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 194-196, 2nd Ed.) and/or pp. 84-88, Being a Nursing Aide, 2nd Ed.

2. Watch the demonstration by the instructor.

3. Practice the procedure.

4. List three (3) reasons for application of siderails.

5. Perform a return demonstration for your instructor or a fellow student.

6. Complete the Self-Check Test for this task.

SELF-CHECK TEST

Adjust Siderails for Patient Safety
I-D-2

1. What are four (4) reasons for the application of siderails?

2. Give at least two examples of patient situations that would indicate the use of siderails.

3. Who determines when the siderails are used?

4. Give an example of how you would record on the patient's chart the application of siderails.

ANSWER KEY

Adjust Siderails for Patient Safety
I-D-2

1. a. Decrease the number of patient falls out of bed.
   b. Reminds the patient that the edge of bed is near and may be in danger of falling out of bed.
   c. Helps the patient to lift or turn himself.
   d. Provides security to the patient without causing him to feel penned in.

2. Examples of patient situations:
   - Post-operative
   - Unconscious
   - Coma
   - Restless
   - Confused
   - Infant
   - Child
   - Elderly

3. Any nursing personnel - nurse, nursing assistant, or doctor.

4. Include the patient's name, room and bed, time, the task performed, and the reason for the application of siderails.

Student Competency Sheet

Unit I: MAINTAINING A CLEAN, SAFE ENVIRONMENT

Module D: Bed Preparation and Adjustment

Task 3: MAKE UNOCCUPIED, SURGICAL OR OPEN BED

Performance Checklist

1. Wash hands.
2. Assemble linens and place in order of use.
3. Position bed.
4. Move mattress to the head of the bed.
5. Place mattress pad on bed.
6. Place bottom sheet on bed.
7. Place rubber sheet or protective pad(s) (if applicable) and draw sheet on bed.
8. Continue to make unoccupied bed by:
   a. Placing top sheet, blanket and spread on 1/2 of bed close to you.
   b. Repeat process on other side of bed.
   c. Pull all linens tight and tuck.
   d. Change pillowcase and place pillow on bed.
9. Continue to make surgical bed by:
   a. Placing top covers on without tucking.
   b. Extend top covers to head of bed even with the edge of the mattress.
   c. Fan-fold top covers to the side or foot of bed.
   d. Replace pillow with towel or disposable pad.
   e. Check safety devices.
   f. Place bed in high position.
10. Continue to make open bed by:
    a. Placing top covers on bed.
    b. Fold top of spread under top edge of blanket.
    c. Fold sheet over spread making a cuff.
    d. Fan-fold top linens to foot of bed.

Test

Items Needed:
1. Hospital bed
2. Mattress pad
3. Sheets
4. Rubber sheet or protective pads
5. Blanket
6. Pillow
7. Pillowcase

Task:
1. Make an unoccupied bed.
2. Make a surgical bed.
3. Make an open bed.

Standard:
1. The linen must be tight.
2. The bed must be ready to receive a patient.
3. Performance checksheet must be completed as "acceptable."

Learning Activities

1. Read pages 139-159, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 199-207, 2nd Ed.) and pages 5-11 to 5-18, Being a Nursing Aide, 1st Ed. (pp. 70-84, 2nd Ed.).

2. Watch a demonstration by your instructor.
3. Watch the filmstrip, "Making an Unoccupied Bed" - Pro Tech Media.
4. Practice the procedures.
5. Perform a return demonstration for your instructor or a fellow student. Note their suggestions.
6. Time your completion of this procedure. (Can you complete it more efficiently?)
7. Performance checksheet must be completed as "acceptable" for all three beds.

Name ____________________
Date ____________________

PERFORMANCE CHECK

Unit I, Module D, Task 3

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Make an occupied bed. (Standards 1 and 2 on Student Competency Sheet _must_ be met).		
2. Make a surgical bed. (Standards 1 and 2 on Student Competency Sheet _must_ be met).		
3. Make an open bed. (Standards 1 and 2 on Student Competency Sheet _must_ be met).		

Student Competency Sheet

Unit I: MAINTAINING A CLEAN, SAFE ENVIRONMENT

Module D: Bed Preparation and Adjustment

Task 4: MAKE OCCUPIED BED

Performance Checklist

1. Wash hands.
2. Collect necessary supplies and stack linen in order of use.
3. Provide for patient's privacy.
4. Describe procedure to patient.
5. Position bed in high, flat position, if allowed.
6. Put side rail up.
7. Move patient to one side of bed.
8. Remove foundation linens (one side).
9. Make the foundation of the bed (one side).
10. Put side rail up.
11. Move patient to clean side of bed.
12. Position pillow under patient.
13. Move to the other side of the bed, lower side rail and pull dirty linen through with clean foundation linen.
14. Reposition patient.
15. Place top linens over patient pulling dirty top layer out underneath clean top linens.
16. Make toe pleat.
17. Change pillow case by gathering clean case down to corners and pulling up over pillow.
18. Place pillow in comfortable position, with attention to good body alignment.
19. Attach signal cord.
20. Adjust side rails.
21. Return bed to low position.
22. Remove soiled linen.
23. Wash hands.

Test

Items Needed:
1. Patient
2. Hospital bed with siderail
3. Mattress pad
4. Linen sheets
5. Rubber sheet
6. Blanket
7. Pillow
8. Pillowcase

Task: Make an occupied bed.

Standard:
1. The patient must be moved correctly and with minimum discomfort.
2. Bottom linens must be tight.
3. Top linens must be non-constricting.

Learning Activities

1. Read pages 139-161, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 207-210, 2nd Ed.) and/or Chapter 6-22 to 6-27, Being a Nursing Aide, 1st Ed. (pp. 84-88, 2nd Ed.).

2. Watch the demonstration by the instructor.
3. Practice the procedure.
4. Watch the filmstrip from Trainex, "Occupied Bed Making."
5. Discuss, in small groups, the safety factors involved when making the occupied bed.
6. Perform a return demonstration for your instructor.
7. Take the written evaluation for this task. Have your instructor check your answers. Your answers must be 85% accurate.

Student Competency Sheet

Unit I: MAINTAINING A CLEAN, SAFE ENVIRONMENT

Module D: Bed Preparation and Adjustment

Task 5: PUT FOOTBOARD OR OVERBED CRADLE ON BED

Performance Checklist

1. Obtain footboard or cradle.
2. Place footboard between the end of the mattress and the foot of the bed.
    a. Loosen top bedding and pull from beneath mattress.
    b. Place one end of "L" shaped footboard under mattress.
    c. Pad footboard.
    d. Bring top bedding over the top of the footboard.
    e. Tuck top bedding under footboard at foot of mattress.
3. Place overbed cradle at foot of bed.
    a. Loosen top bedding and pull from beneath mattress.
    b. Place cradle over the bottom bedding.
    c. Bring top bedding over the top of the cradle.
    d. Tuck top bedding under mattress at foot of the bed.

Test

Items Needed:	1. Hospital bed with bedding 2. Footboard or overbed cradle
Task:	Put the footboard or overbed cradle on the bed.
Standard:	The footboard or overbed cradle must be positioned to prevent the top bed linens from coming in contact with the patient's extremities.

Learning Activities

1. Read pages 311-318, Nursing Skills for Allied Health Services, Vo. I, 1st Ed. (pp. 105 and 110, 2nd Ed.) and/or pages 67-68, Being a Nursing Aide, 2nd. Ed.

2. Watch the demonstration by the instructor.

3. Practice the procedure.

4. Discuss the reasons for changing the patient's position.

5. List eight (8) checkpoints of good body alignment.

6. List two (2) reasons for the application of a footboard and overbed cradle.

7. Take the written evaluation. Your answers must be 85% accurate.

Student Competency Sheet

Unit I: MAINTAINING A CLEAN, SAFE ENVIRONMENT

Module D: Bed Preparation and Adjustment

Task 6: PUT ALTERNATING PRESSURE MATTRESS ON BED

Performance Checklist

1. Check physician's orders.
2. Obtain alternating pressure mattress.
3. Strip bed.
4. Place alternating pressure mattress on bed.
5. Attach hoses to pump (avoid kinking).
6. Plug motor pump into electrical outlet.
7. Cover mattress with bottom sheet.
8. Apply top linens.
9. Record procedure.

Test

Items Needed:
1. Physician's orders
2. Hospital bed
3. Alternating pressure mattress
4. Sheets

Task:
1. Put the alternating pressure mattress on the bed.
2. Make the bed ready for occupancy.

Standard:
1. The bed must be expanded to comply with the physician's orders.
2. The bed must be made ready for occupancy.

Learning Activities

1. Read page 68, *Being a Nursing Aide*, 2nd Ed. and pages 109-110, *Nursing Skills for Allied Health Services*, Vol. I, 2nd Ed.

2. Watch a demonstration by your instructor.

3. Watch, as available, "Prevention and Treatment of Decubitus Ulcers" - Trainade; "Positioning to Prevent Complications" - Trainex.

4. Practice applying the alternating pressure mattress.

5. Perform a return demonstration for your instructor.

UNIT II

CARING FOR THE PERSONAL NEEDS OF PATIENTS

Terminal Objectives

Upon completion of modules in this unit, you will:

- Give or assist with dental care for conscious or helpless patients.
- Give or assist with bathing and personal care and give back rubs.
- Give skin care to patients with decubitus ulcers and helpless patients who are comatose or semi-comatose or in casts or traction or restraints.
- Give skin care to prevent bedsores.
- Assist patients to dress or undress.
- Carry, bathe, dress and feed a newborn infant.
- Care for a newborn infant's umbilical cord, circumcision and genitalia.
- Obtain and apply identification of a newborn infant and its mother.
- Weigh and measure an infant.
- Suction an infant's respiratory passage.
- Irrigate an infant's eyes with silver nitrate.
- Assist patients to put on or remove braces.
- Assist patients to dangle, stand, walk, and use a walker, cane or crutches.
- Position trochanter rolls and/or sandbags.
- Transfer patients to and from a stretcher using a transfer sheet or a three-man lift.
- Transport patients by stretcher or wheelchair.
- Assist patients to and from a wheelchair and teach them how to use a wheelchair.
- Use a mechanical lifter to transfer a patient from the bed to a wheelch .

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module A: Oral Hygiene

Task 1: ASSIST A CONSCIOUS PATIENT TO MAINTAIN ORAL HYGIENE

Performance Checklist

1. Assemble equipment.
2. Identify patient and explain procedure.
3. Provide privacy for patient.
4. Wash hands.
5. Place towel across patient's chest.
6. Elevate bed, if not contraindicated.
7. Wet toothbrush and spread toothpaste.
8. Place emesis basin under patient's chin.
9. Provide patient with glass of water.
10. Instruct patient to brush teeth if able to do so; if not, assist as necessary.
11. Instruct patient to rinse mouth thoroughly.
12. Wipe patient's mouth when completed.
13. Apply lubricant to lips and tongue if dry and cracked.
14. Rinse toothbrush and emesis basin and return to proper storage.
15. Provide for patient's comfort.
16. Wash hands.

Test

Items Needed:

1. Conscious patient
2. Toothbrush
3. Toothpaste
4. Cup of water
5. Emesis basin
6. Mouthwash
7. Tissues or towel
8. Optional - Dental floss

Task: Assist a conscious patient with oral hygiene.

Standard: The oral cavity must be thoroughly cleansed.

Learning Activities

1. Read pages 7-1 and 7-2, Being a Nursing Aide, 1st Ed. (pp. 124-126, 2nd Ed.) and/or pages 184-186, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 242-243, 2nd Ed.).
2. Practice the procedure with a fellow student.
3. Participate as "patient" and as nursing personnel giving care.
4. Evaluate fellow students during your practice sessions.
5. Discuss, in small groups, the importance of good oral hygiene to general good health.
6. Record several important points from your discussions. Share them with your instructor and incorporate them in your patient teaching.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module A: Oral Hygiene

Task 2: GIVE ORAL HYGIENE FOR A HELPLESS PATIENT

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Gather equipment and place on table near bed.
5. Turn patient's head to one side.
6. Place towel and emesis basin under chin.
7. Cleanse entire mouth with swabs. Keep mouth open with tongue depressor, if necessary.
8. Rinse mouth with small amounts of liquid; allow solution to drain into emesis basin (except for unconscious patients).
9. Lubricate lips.
10. Clean and replace equipment.
11. Leave patient clean and comfortable.
12. Wash hands.

Test

Items Needed:

1. Helpless patient
2. Mouth lubricant
3. Mouth swabs
4. Patient's oral hygiene supplies
5. Towel
6. Cup of water
7. Emesis basin
8. Tongue depressor

Task: Give oral hygiene to a helpless patient.

Standard:

1. The oral cavity must be thoroughly cleansed.
2. All checksheet items must be rated acceptable.

Learning Activities

1. Read pages 7-3 to 7-4, Being a Nursing Aide, 1st Ed. (pp. 124-129, 2nd Ed.) and/or page 90, Nurses Aide Study Manual, Mayes.

2. Observe a demonstration by your instructor.

3. Discuss, with your instructor, any questions you may have about this procedure.

4. Practice oral hygiene of the helpless patient with a classmate or laboratory mannequin.

5. List special precautions to be observed if the helpless patient is (1) unconscious, (2) a young child. Compare your list with fellow students and discuss the precautions with your instructor.

6. Role play a patient care situation in which you are explaining mouth care to a helpless patient and his family.

7. Complete the performance checksheet for this task.

Name__________________________
Date__________________________
Unit II, Module A, Task 2

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Wash hands.		
2. Identify patient.		
3. Explain procedure.		
4. Gather equipment and place on table near bed.		
5. Turn patient's head to one side.		
6. Place towel and emesis basin under chin.		
7. Cleanse entire mouth with swabs. Keep mouth open with tongue depressor, if necessary.		
8. Rinse mouth with small amounts of liquid; allow solution to drain into emesis basin (except for unconscious patients).		
9. Lubricate lips.		
10. Clean and replace equipment.		
11. Leave patient clean and comfortable.		
12. Wash hands.		

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module A: Oral Hygiene

Task 3: GIVE OR ASSIST WITH ORAL HYGIENE (DENTURE CARE)

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Ask patient to remove dentures or remove dentures if patient is unable to do so.
5. Place dentures in emesis basin or denture cup and take to sink.
6. Fill sink with water.
7. Brush dentures, down on upper teeth and up on lower teeth.
8. Rinse dentures with running water.
9. Allow patient to wash mouth.
10. Let patient put dentures in mouth or do it for patient.
11. Dry patient's mouth and hands.
12. Wash hands.

Test

Items Needed:
1. Dentures
2. Toothbrush
3. Toothpaste
4. Basin
5. Towel
6. Mouthwash

Task: Clean dentures.

Standard:
1. The dentures must be clean.
2. The dentures must not be dropped.

Learning Activities

1. Read pages 7-3 to 7-5, Being a Nursing Aide, 1st Ed. (pp. 124-128, 2nd Ed.).
2. Practice handling and brushing dentures in the classroom.
3. Discuss with your instructor any questions you may have.
4. Examine commercial denture cleansers provided by your instructor.
5. Demonstrate denture care for a small group of fellow students and have them evaluate your performance.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module B: General Body Hygiene

Task 1: ASSIST WITH TUB BATH

Performance Checklist

1. Assemble equipment and supplies.
2. Identify patient and explain procedure.
3. Wash hands.
4. Fill bath tub 1/2 full with water (100°F. or 37.7° - 46.1°C.)
5. Place "OCCUPIED" or "TREATMENT IN PROGRESS" sign on door.
6. Escort patient to tub.
7. Assist patient into tub.
8. Place portable call signal on straight-back chair at side of tub if wall signal is not present.
9. Check patient at frequent intervals.
10. Assist patient in bathing, as necessary.
11. Upon completion of bath, assist patient in stepping from tub.
12. Assist with drying and dressing, if necessary.
13. Accompany patient to his/her bed.
14. Provide for patient's comfort.
15. Restore bathtub facilities to usable condition.
16. Record pertinent observations.

Test

Items Needed:

1. Patient
2. Bathroom with tub facilities
3. Towel
4. Washcloth
5. Soap
6. Chair
7. Portable or wall call signal
8. Robe
9. Slippers
10. Bath thermometer

Task: Assist the patient in taking a tub bath.

Standard:

1. The patient must be clean upon completion of bath.
2. Bathtub facilities must be restored to usable condition.

Learning Activities

1. Read pages 7-14 to 7-16, Being a Nursing Aide, 1st Ed. (pp. 139-140, 2nd Ed.).
2. Read pages 176-177, The Nursing Assistant, Donovan, Belsjoe, and Dillon.
3. Practice assisting and lifting your classmates in and out of a tub.
4. Determine a safe range for the bath water temperature by using a bath thermometer. Recheck Performance Checklist.

5. Practice measuring the correct water temperature, using your wrist as a guide. SAFETY NOTE: Do not use a temperature that is ideal for you. It may be too hot for your patient.

6. List on paper safety precautions needed to assist with a tub bath.

7. Discuss, in small groups, the importance of privacy during the bath and how the nursing personnel may assist in maintaining patient privacy.

8. Watch, as available, "Bathing the Patient: Shower and Tub Bath" - Pro-Tech and/or "Showers and Tub Baths" - Trainex.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module B: General Body Hygiene

Task 2: ASSIST WITH SHOWER

Performance Checklist

1. Identify the patient and explain procedure.
2. Wash hands.
3. Assemble equipment and supplies.
4. Escort the patient to the shower area.
5. Provide for the patient's privacy and safety.
   NOTE: Place chair in bathroom and "OCCUPIED" sign on door, if necessary.
6. Adjust water temperature and force for comfort.
7. Assist the patient as necessary.
8. If patient is able to be left alone, instruct him/her in the use of emergency call signal.
9. Escort the patient back to bed.
10. Make patient comfortable.
11. Return shower facilities to usable condition.
12. Record pertinent observations.

Test

Items Needed:
1. Patient
2. Shower facilities
3. Robe
4. Slippers
5. Towel
6. Washcloth
7. Soap
8. "OCCUPIED" sign
9. Chair

Task: Assist the patient in taking a shower.

Standard:
1. The patient must be clean upon completion of the shower.
2. Shower facilities must be returned to clean and reusable condition.

Learning Activities

1. Read pages 7-14 to 7-15, Being a Nursing Aide, 1st Ed. (p. 141, 2nd Ed.).

2. Read page 95, Nurses Aide Study Manual, Mayes.

3. List on paper safety precautions needed to assist with a shower bath.

4. Discuss with your instructor any questions you may have about assisting a patient with a shower.

5. Role play assisting a fellow student with a shower.

6. Perform such role-play demonstrations for your instructor. Have your instructor evaluate your performance.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module B: General Body Hygiene

Task 3: GIVE BACK RUB

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Provide patient privacy.
5. Place bed in high position.
6. Move patient to near side of bed in prone or lateral position.
7. Stand with feet twelve (12) inches apart, with one foot in front of the other.
8. Wash and dry back.
9. Place lotion in palms of hands, using friction of hands to warm lotion.
10. Rub neck with fingers using circular motions to the hairline.
11. Place hands on sacral area, and rub toward the neckline with long smooth strokes
12. Continue down toward sacrum with broad circular motions.
13. Continue with long, smooth strokes over the entire back from shoulder to sacrum.
14. Continue rubbing for 3-5 minutes, until all lotion is absorbed.
15. Apply powder to hands, and apply long, smooth strokes over back from shoulders to sacrum.
16. Check for and report all broken and reddened areas.
17. Replace equipment.
18. Leave patient in comfortable position.

Test

Items Needed:

1. Patient
2. Soap
3. Basin of warm water
4. Towel
5. Back lotion
6. Powder

Task:

1. Give a back rub to the patient.
2. Check for and report all broken and/or reddened areas.

Standard:

1. Circular motions and long, smooth strokes must be used.
2. The student's findings must agree with the instructor's findings with regard to any abnormal skin conditions.
3. All checksheet items must be rated acceptable.

Learning Activities

1. Read pages 7-16 to 7-17, Being a Nursing Aide, 1st Ed. (pp. 141-143, 2nd Ed.) and/or page 193, Nursing Skills for Allied Health Services, 1st Ed. (p. 249, 2nd Ed.).

2. Observe a demonstration by your instructor.

3. Practice the task with fellow students, assuming the roles of patient and nursing personnel.

4. Complete the performance checksheet for this task.

Name_________________________
Date_________________________
Unit II, Module B, Task 3

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Washed hands.		
2. Identified patient and explained procedure.		
3. Provided for privacy and adjusted patient's position.		
4. Used good body mechanics.		
5. Used circular motion on neck.		
6. Used long, smooth strokes on back.		
7. Observed and recorded abnormal skin conditions.		
8. Repeated procedure for 3-5 minutes.		
9. Provided for patient's comfort.		

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module B: General Body Hygiene

Task 4: GIVE OR ASSIST PATIENT WITH BED BATH

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Gather equipment.
5. Check temperature of room and eliminate drafts.
6. Raise bed to working height.
7. Provide for privacy.
8. Place bath blanket over patient.
9. Fanfold bed linens to foot of bed - do not expose patient.
10. Prepare bath water at 110°F - 115°F.
11. Remove gown or pajamas.
12. Place face towel across chest.
13. Form wash cloth into mitt over hand.
14. Wash eye area from inner cannula to outer cannula.
15. Wash and dry face and neck; use soap only if desired by the patient.
16. Place bath towel under arm on farthest side from you and wash and dry.
17. Place hand in basin, soak and give nail care.
18. Wash other arm in same manner.
19. Use deodorant or powder, if appropriate.
20. Place towel over chest and fanfold bath blanket to waistline.
21. Wash, rinse and dry chest using a circular motion without exposing.
22. Fold blanket to pubic bone and wash, rinse and dry lower abdomen. Replace blanket.
23. Place towel lengthwise under far leg and tuck bath blanket around upper leg to prevent draft.
24. Place basin on bed and put foot into it.
25. Wash and rinse leg from hip to knee.
26. Wash and rinse from knee to foot.
27. Wash foot - dry very thoroughly.
28. Wash, rinse and dry other leg and foot in same way.
29. Obtain fresh water.
30. Turn patient to side. Place towel at bedline.
31. Wash back with long, soothing strokes.
32. Give back rub according to procedure.
33. Wash, rinse and dry perineal area.
34. Put on clean gown or pajamas.
35. Place bed in low position.
36. Attach signal bell and bedside table within reach.
37. Leave patient comfortable and in good alignment.
38. Replace equipment and tidy room.

Test

Items Needed:
1. Patient
2. Bath towel
3. Face towel (optional)
4. Wash cloth
5. Bath thermometer
6. Soap
7. Patient's clean clothes
8. Deodorant
9. Powder or lotion
10. Bath blanket

Task: Administer a complete bed bath.

Standard:
1. Patient has privacy and is comfortable.
2. Patient is clean.
3. There is strict adherence to rules regarding the safety of the patient.
4. All checksheet items must be rated acceptable.

Learning Activities

1. Read pages 7-7 to 7-12, Being a Nursing Aide, 1st Ed. (pp. 130-137, 2nd Ed.) and/or pages 190-195, Nursing Skills for Allied Health Services, 1st Ed. (pp. 233-239 and 246-250, 2nd Ed.).
2. Observe a demonstration of the bed bath by your instructor.
3. Watch filmstrip "The Bed Bath" - Trainex and/or "Bathing the Patient" - Trainex.
4. Practice giving or assisting with a complete bed bath to a classmate.
5. Role play a nursing care situation. Administer a bed bath to a fellow student.
6. Role play a nursing care situation. Participate as the "patient" receiving a bed bath.
7. Complete the performance checksheet for this task.
8. Complete the Self-Check Test for this task. Check your answers with the Answer Key.

Name______________________________

Date______________________________

Unit II, Module B, Task 4

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Bath is completed. Patient's privacy has been maintained.		
2. Bath is completed. Patient has remained comfortable and warm throughout the care.		
3. Bath is completed. Patient is clean.		
4. Bath is completed with strict adherence to rules regarding safety of the patient.		

SELF-CHECK TEST
II-B-4

Anatomy of the Skin

To extend your knowledge of the skin, complete this study guide. Check your answers with the Answer Key on this page.

1. List below four functions of the skin.

   1. 3.
   2. 4.

2. Another name for skin is ______________________________.

3. Name the three layers of skin.

   1. 2. 3.

4. What is the name of the hollow tube of epithelial cells in which the hair shaft and root grows?

5. Name the gland of the skin that produces an oily secretion.

6. Name the gland of the skin that produces perspiration.

7. Skin color is due largely to the presence of pigment granules called __________.

ANSWER KEY

1. a. Protection c. Provides sensation
   b. Regulation of body temperature d. Excretion
2. Integument
3. a. Epidermis b. Dermis c. Subcutaneous
4. Follicle
5. Sebaceous
6. Eccrine gland
7. Melanin

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module B: General Body Hygiene

Task 5: GIVE PERINEAL CARE

Performance Checklist

1. Wash hands.
2. Gather necessary supplies.
3. Identify patient.
4. Explain procedure.
5. Screen patient for privacy.
6. Prepare and position patient on the bedpan, draping appropriately.
7. Pour designated warmed (105°F or 40.5°C) solution over perineal area.
8. For female patient, clean by making downward strokes, using one cotton ball for each stroke.
9. Rinse and dry, beginning in the outer perineal area, if appropriate.
10. For male patient, clean the tip of the penis first using circular motions; continue cleaning the remainder of the genital area.
11. Dispose of cotton balls or wipes appropriately.
12. Remove bedpan.
13. Ask patient to turn.
14. Dry buttocks.
15. Apply clean dressing or pad.
16. Provide for patient comfort.
17. Clean and store equipment.
18. Report procedure and any unusual observations.

Test

Items Needed:
1. Patient
2. Perineal bottle
3. Solution
4. Bedpan
5. Cotton balls or wipes
6. Bath blanket

Task: Give perineal care to the patient.

Standard:
1. The prescribed solution must be used at the correct temperature.
2. The perineal area must be cleaned and dried in a manner consistent with patient's sex.

Learning Activities

1. Read pages 488-492, Nursing Skills for Allied Health Services, 1st Ed. (pp. 684-685, 2nd Ed.).

2. Watch filmstrip "Peri-Care" - Trainex.

3. List and define vocabulary terms on page 488, Nursing Skills for Allied Healt Services, Vol. III, 1st Ed.

4. Observe a demonstration by your instructor, using a laboratory mannequin as the patient.

5. Practice the procedure using the laboratory mannequin.

6. Role play your explanation of this procedure, to a patient, with a fellow classmate.

7. List three examples of patient care situations when this procedure might be an especially important part of patient care.

8. Perform a return demonstration for your instructor. Include a patient explanation in your return demonstration.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module B: General Body Hygiene

Task 6: ASSIST WITH OR SHAVE THE MALE PATIENT

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Gather equipment.
5. Elevate head of bed, unless not advised.
6. Place towel across chest.
7. Moisten and lather face, being careful not to allow lather to get into the eyes.
8. Shave, using short, smooth strokes and holding skin taut.
9. Start in front of the ear and work toward chin.
10. Continue on other side until all lather is removed.
11. Rinse razor frequently.
12. Lather neck and shave upward toward the chin.
13. Wash and rinse the face.
14. Apply aftershave lotion or powder.
15. Clean and store equipment.
16. Leave patient clean and comfortable.
17. Wash hands.

Test

Items Needed:
1. Male patient
2. Safety razor
3. Shaving cream
4. Aftershave lotion or powder
5. Towel
6. Hot water

Task: Shave the patient with a safety razor.

Standard:
1. Shave the patient with the least amount of discomfort.
2. The face must be clean-shaven with no cuts or scratches.

Learning Activities

1. Read pages 7-30 to 7-32, Being a Nursing Aide, 1st Ed. (pp. 149-151, 2nd Ed.), and pages 97-98, Nurses Aide Study Manual, Mayes.

2. Observe a demonstration of shaving a male by your instructor.

3. Practice shaving male members of your class.

4. Have your fellow students and your instructor evaluate your performance.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module B: General Body Hygiene

Task 7: CARE FOR OR ASSIST PATIENT IN CARING FOR HAIR

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Place clean towel on pillow under patient's head.
5. Turn head away from you.
6. Part the hair in three (3) main sections.
7. Comb or brush beginning at ends and working toward the scalp (use alcohol solution for tangled hair).
8. Avoid pulling by keeping hand on hair between scalp and end.
9. Brush or comb until hair is smooth from scalp to ends over entire head.
10. Arrange hair attractively and comfortably.
11. Remove towel.
12. Clean and replace equipment.
13. Wash hands.
14. Report and record procedure.

Test

Items Needed:
1. Patient
2. Towel
3. Comb
4. Brush
5. Alcohol solution

Task: Assist helpless patient to care for hair by demonstrating daily hair care.

Standard:
1. Hair must be combed or brushed gently to free tangles.
2. Hair must be arranged neatly.

Learning Activities

1. Read page 182, The Nursing Assistant, Donovan, Belsjoe, and Dillon.
   Read pages 7-32 to 7-33, Being a Nursing Aide, 1st Ed. (pp. 148-149 2nd Ed.).
   Read pages 203-206, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 662-681, Vol. II, 2nd Ed.).

2. Practice combing, brushing and braiding the hair of your classmate in bed or in the chair.

3. List on paper things to be observed while caring for the patient's hair.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module B: General Body Hygiene

Task 8: GIVE SHAMPOO TO A BED PATIENT

Performance Checklist

1. Check physician's orders.
2. Assemble all materials.
3. Identify patient and explain procedure.
4. Provide for protection of bed and floor.
5. Prevent drafts.
6. Protect patient's eyes and ears.
7. Provide for continuous drainage of shampoo water.
8. Shampoo hair.
9. Rinse and dry hair.
10. Comb out tangles.
11. Tidy area.
12. Report and record procedure.

Test

Items Needed:
1. Patient
2. Shampoo
3. Physician's order
4. Brush
5. Comb
6. Towels
7. Warm water
8. Basin
9. Protective clothes

Task: Shampoo the patient's hair.

Standard: The shampoo must leave the hair clean.

Learning Activities

1. Read pages 7-20 to 7-23, Being a Nursing Aide, 1st Ed. (pp. 146-147 2nd Ed.).

2. Practice arranging a unit with a patient for a bed shampoo.

3. Practice a bed shampoo with the laboratory mannequin.

4. Complete the Self-Check Test.

5. Role play a patient care situation. Shampoo the hair of a classmate or the laboratory mannequin. Have your fellow students or your instructor evaluate your performance.

SELF-CHECK TEST

Give Shampoo to a Bed Patient
II-B-8

1. State two reasons why shampooing the patient's hair is important.
2. How can you prevent chilling of the patient during a shampoo?
3. How can you keep soap and water out of the patient's eyes and ears?
4. How can you avoid soaking the bed?

ANSWER KEY

1. Important to the patient for their appearance and general cleanliness.
2. Bath blankets covering the body and a towel wrapped turban style around the head until it's dry.
3. Shield eyes with dry wash cloth while pouring. Cover ear with hand and/or place cotton ball in ear.
4. Trough made by rubber sheeting, dropping into bucket. A commercial shampoo tray can also be used.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module B: General Body Hygiene

Task 9: CARE FOR OR ASSIST PATIENT IN CARING FOR TOENAILS AND FINGERNAILS

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Soak hands or feet in warm soapy water. Use hand brush, if necessary, for cleanliness.
5. Push back softened cuticle with orangewood stick.
6. Clean under nails with orangewood stick.
7. Dry patient's hands or feet.
8. Cut or file nail straight across, if needed.
9. Observe for redness, cyanosis, hangnails, infection or signs of ingrowing.
10. Apply lotion if skin is dry.
11. Wash hands.
12. Report and record procedure and pertinent observations.

Test

Items Needed:

1. Patient
2. Orangewood stick
3. Basin of warm water
4. Blunt scissors
5. Lotion
6. Towel

Task: Give toenail and fingernail care.

Standard:

1. Nails must be clean.
2. Nails must be trimmed to a length to allow white to show under the entire end of the nail.
3. There must be no rough edges, skin breaks or irritation.

Learning Activities

1. Discuss, in small groups, with the direction of your instructor, the safety precautions for nail care.

2. Practice nail care with a fellow student or the laboratory mannequin. Have your instructor evaluate your performance.

3. Practice recording pertinent observations following nail care.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module C: Skin Care

Task 1: ASSIST WITH PREVENTING BEDSORES

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Observe patient's skin frequently for poor circulation.
5. Change patient's position at least every two (2) hours.
6. Keep patient clean and dry.
7. Massage patient over bony prominences to maintain circulation.
8. Keep linens dry and wrinkle free.
9. Do passive range of motion exercises or encourage active exercise.
10. Report observations.

Test

Items Needed: Bed-ridden patient

Task: Take the necessary steps to prevent bedsores.

Standard:
1. Adequate circulation must be maintained.
2. The patient's position must be changed at least every two (2) hours.

Learning Activities

1. Read pages 7-36 to 7-37, Being a Nursing Aide, 1st Ed. (pp. 158-160, 2nd Ed.), and/or pages 118-120, Nurses Aide Study Manual, Mayes.

2. Watch filmstrip "Prevention and Treatment of Decubitus Ulcers" - Trainade.

3. Read Information Sheet II-C-1.

INFORMATION SHEET
II-C-1

Specially Designed Surfaces for the Prevention of Decubitus Ulcers (Bedsores)

1. The Airmass Alternating Pressure Pad is placed on top of a regular mattress. It is designed as a nursing aid for the prevention of bed sores. It is a pneumatic mattress with air cells running up and down its entire length. The air cells empty and fill so that when parts of the cells are empty, others fill; thus, no part of the body is under pressure longer than ninety (90) seconds. Care should be taken not to puncture it with pins when fastening the bell signal or tubes to the sheet.

2. Stryker Flotation Pad with Spence Gel, a Poly-nent mattress, is placed on top of the regular mattress and is covered with a sheet. The flotation pad is placed on top of the sheet. The patient is positioned on the pad with the coccyx area resting on the pad. The pad is constructed of a delicate material called Spence Gel and is covered by a thin elastic membrane to protect the gel. It may be autoclaved or cleaned with germicides. The pad may be used on a chair for the patient to sit on.

3. The Water Bed is also designed as a flotation device to support the body without concentrating pressure over any weight-bearing area of the body. It has been proven that, when the patient is placed in the water bed, frequent turning is not required. Water beds are extremely heavy. The head of the bed cannot be elevated.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module C: Skin Care

Task 2: GIVE SKIN CARE TO PATIENT WITH DECUBITUS ULCERS

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Check patient for cleanliness and dryness.
5. Turn patient to side.
6. Observe skin color for signs of tissue breakdown, i.e. red, blue, or mottled.
7. Give back rub.
8. Change patient's position.
9. Massage bony prominences and any reddened areas.
10. Position patient off decubitus areas.
11. Report and record procedure and observations.
12. Leave patient comfortable, clean, dry, and in good alignment.

Test

Items Needed:
1. Patient with decubitus ulcers
2. Lotion
3. Towel
4. Soap
5. Basin of warm water
6. Powder

Task:
1. Give skin care to patient with decubitus ulcers.
2. Report and record procedure and observations.

Standard:
1. All bony prominences and reddened areas must be massaged.
2. The patient must be positioned in good alignment, off decubitus areas.
3. The student's findings must agree with the instructor's findings with regard to abnormal skin conditions.

Learning Activities

1. Observe a demonstration by your instructor, giving care to a patient with decubitus ulcers or to the laboratory mannequin.

2. Practice giving such care with the laboratory mannequin as the patient.

3. Watch "Prevention and Treatment of Decubitus Ulcers" by Trainade.

4. Practice recording your observations of the tissue breakdown illustrated in the filmstrip.

5. List and define new terms used to describe damaged tissue.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module C: Skin Care

Tash 3: GIVE SKIN CARE TO COMATOSE OR SEMICOMATOSE PATIENT

Performance Checklist

1. Gather proper equipment.
2. Wash hands.
3. Identify patient.
4. Explain procedure.
5. Provide privacy.
6. Place patient in supine position with legs flexed.
7. Wash and rinse perineal area, and pat dry.
8. Put siderail up.
9. Change water.
10. Turn patient to side.
11. Wash and dry back.
12. Give back rub, giving special attention to any reddened areas and bony prominences.
13. Inspect all areas of the body for signs of tissue breakdown.
14. Change linens if necessary.
15. Position patient in good body alignment.
16. Put siderail up.
17. Leave patient comfortable.
18. Report procedure and any pertinent observations.

Test

Items Needed:
1. Comatose patient
2. Lotion
3. Towel
4. Soap
5. Basin of warm water
6. Powder

Task:
1. Give skin care.
2. Report procedure and observations.

Standard:
1. The patient's position must be changed depending upon the conditions.
2. The patient's skin must be clean and dry.
3. All bony prominences and reddened areas must be massaged.
4. The student's findings must agree with the instructor's findings with regard to any abnormal skin conditions.

Learning Activities

1. Read page 228, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 446-448, 2nd Ed.).

2. Practice this task with the laboratory mannequin as the patient.

3. Practice turning and positioning the mannequin with the help of a fellow student.

4. Identify ways in which two individuals might be better able to turn and position the comatose or semicomatose patient.

5. In small groups, and with your instructor, discuss pertinent observations that should be made when caring for the comatose or semicomotose patient.

6. Complete the Self-Check Test provided. Check your answers with the Key.

SELF-CHECK TEST

Give Skin Care to Comatose or Semicomatose Patient
II-C-3

True or False

1. Patients with poor circulation are more likely than others to have bedsores.
2. Keeping the patient's body absolutely clean and dry helps to prevent bedsores.
3. Comatose patients or semicomatose patients need to be turned often to avoid pressure on the tissues.
4. Urine and feces when left on the skin lead to burned areas known as excoriation.
5. Body signs of tissue breakdown would include blanching of the skin, tenderness, burning sensation, and redness.

ANSWER KEY

1. T
2. T
3. T
4. T
5. T

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module C: Skin Care

Task 4: GIVE SKIN CARE TO A PATIENT IN CASTS AND/OR TRACTION

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Provide privacy.
5. Adjust bed to high position.
6. Check to be sure patient is in good body alignment.
7. Check for signs of impaired circulation, i.e. discoloration, coldness, pain, numbness, or edema.
8. Smell and feel cast for indications of skin breakdown.
9. Check edges of cast for roughness.
10. Reinforce edges of cast with stockinette as needed.
11. Check for redness of skin caused by irritation of cast or traction apparatus.
12. Use pillows to prevent pressure areas and maintain good alignment of the extremity.
13. Check traction ropes to make certain they are hanging free and are providing adequate pull.
14. Turn patient as permitted and give back care.
15. Check entire body for reddened areas and massage as needed.
16. Straighten linens.
17. Leave patient clean, dry and in good body alignment.
18. Report procedure and any pertinent observations.

Test

Items Needed:
1. Patient in cast or in traction
2. Lotion
3. Towel
4. Soap
5. Basin of warm water
6. Powder
7. Pillows
8. Stockinette

Task:
1. Administer skin care to patient.
2. Report procedure and any pertinent observations.

Standard:
1. All reddened areas must be massaged.
2. Any rough edges of cast must be reinforced.
3. The student's findings must agree with the instructor's findings with regard to impaired circulation and abnormal skin conditions.
4. The patient must be positioned in good body alignment.
5. Traction ropes must hang free and provide adequate pull.
6. All checksheet items must be rated acceptable.

Learning Activities

1. Read pages 230-236, Nursing Skills for Allied Health Services, Vol. I, 1st Ed., (pp. 451-457, 2nd Ed., Vol. II), and/or page 251, The Nursing Assistant, Donovan.

2. Watch filmstrip "Care of the Orthopedic Patient" by Trainade.

3. Watch, as available, "Care of the Patient in Traction" by Trainex.

4. Diagram, with simple stick figures, the various types of casts and traction illustrated in the filmstrip(s) available to you.

5. Watch a demonstration by your instructor of skin care for the patient in casts and/or traction.

6. Practice the nursing care described in this task with a fellow student or the laboratory mannequin.

7. Discuss, in small groups, and with your instructor the three (3) purposes for the application of traction in treating musculo-skeletal conditions.

8. List the five (5) cardinal (alert) signs of impaired circulation of the patient's skin in a cast.

9. Complete the Performance Checksheet.

Name ______________________
Date ______________________

PERFORMANCE CHECK

Unit II, Module C, Task 4

	RATING	
	Acceptable	Unacceptable
1. Wash hands.		
2. Identify Patient.		
3. Explain procedure.		
4. Provide privacy.		
5. Adjust bed to high position.		
6. Check to be sure patient is in good body alignment.		
7. Check for signs of impaired circulation, i.e. discoloration, coldness, pain, numbness or edema.		
8. Smell and feel cast for indications of skin breakdown.		
9. Check edges of cast for roughness.		
10. Reinforce edges of cast with stockinette as needed.		
11. Check for redness of skin caused by irritation of cast or traction apparatus.		
12. Use pillows to prevent pressure areas and maintain good alignment of the extremity.		
13. Check traction ropes to make certain they are hanging free and are providing adequate pull.		
14. Turn patient as permitted and give back care.		
15. Check entire body for reddened areas and massage as needed.		
16. Straighten linens.		
17. Leave patient clean, dry and in good body alignment.		
18. Report procedure and any pertinent observations.		

Student Competency Sheet

Unit II: CARE FOR THE PERSONAL NEEDS OF PATIENTS

Module C: Skin Care

Task 5: APPLY RESTRAINTS

Performance Checklist

1. Check doctor's order and institution's regulations before applying restraints.
2. Wash hands.
3. Identify patient.
4. Explain procedure.
5. Obtain appropriate restraint(s).
6. Apply restraint snugly and gently.
7. Apply pad if necessary.
8. Change position of patient at least every two hours and check circulation of restrained area periodically.
9. Report procedure.

Test

Items Needed:
1. Patient
2. Bed
3. Physician's orders
4. Restraints
5. Padding

Task: Apply restraints as directed.

Standard:
1. Restraint(s) must be applied snugly without causing undue physical discomfort to the patient.
2. The restraint(s) must restrict movement of the applicable body part(s).
3. Circulation must not be impaired.

Learning Activities

1. Read pages 659-670, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 619-623, Vol. II, 2nd Ed.), and/or pages 117-118, Nurses Aide Study Manual, Mayes.

2. Watch filmstrip, "The Use of Protective Restraints" by Trainex.

3. Practice application of all types of restraints available.

4. Role play a patient-care situation of applying restraints. Participate as both a patient and a member of the nursing team.

5. Record your reaction to being immobilized.

6. Record your classmate's reaction to being immobilized.

7. List, during small group discussion, the patient-care situations that might require the use of protective restraints.

8. Discuss these lists with your instructor and compile a more inclusive list for your own reference.

9. Role play the explanation of the need for protective restraints to a patient and his family.

10. Practice reporting and recording pertinent observations of the patient in protective restraints. Have your instructor evaluate your work.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module C: Skin Care

Task 6: GIVE SKIN CARE TO PATIENT IN RESTRAINTS

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure to patient.
4. Provide privacy.
5. Check body alignment.
6. Correct alignment as needed.
7. Check temperature, color, and movability of all extremities.
8. Alternate body position, attaching all restraints to one side of the bed for sidelying positions.
9. Massage all bony prominences and any reddened by the restraints.
10. Remove one restraint at a time.
11. Exercise each extremity.
12. Massage any skin surfaces reddened by the restraints.
13. Replace each restraint.
14. Leave patient clean and in good body alignment.
15. Report procedure and condition of the skin.

Test

Items Needed:
1. Patient in restraints
2. Lotion
3. Towel
4. Basin of warm water
5. Soap
6. Powder

Task:
1. Give skin care to a patient in full restraints.
2. Report procedure and condition of skin.

Standard:
1. All bony prominences and areas reddened by restraints must be massaged.
2. Each restrained extremity must be exercised and the restraints replaced.
3. The student's findings must agree with the instructor's findings with regard to abnormal skin conditions.

Learning Activities

1. Review pages 659-670, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 619-623, Vol. II, 2nd Ed.), and/or pages 117-118, Nurses Aide Study Manual,
2. Watch filmstrip, "The Use of Protective Restraints" by Trainex.
3. Identify areas of the body that would require special skin care and observation when protective restraints are applied.
4. Watch a demonstration by your instructor.

5. Practice this task with fellow students. Give special attention to conditions and needs related to skin care.
6. Note suggestions offered by your instructor and/or fellow students.
7. Perform a return demonstration for your instructor.

Student Competency Sheet

Unit II: CARING FOR PERSONAL NEEDS OF PATIENTS

Module D: Dressing

Task 1: ASSIST PATIENT IN DRESSING AND UNDRESSING

Performance Checklist

1. Wash hands.
2. Identify Patient.
3. Provide privacy.
4. Explain procedure to patient.
5. Gather appropriate clothing.
6. Position bed properly.
7. Remove clothing, being certain to remove from unaffected extremity first.
8. Put on fresh clothing, being certain to place on affected extremity first.
9. Make patient comfortable.
10. Report observations.

Test

Items Needed:
1. Bed
2. Helpless or weak patient
3. Clothing

Task: Assist in dressing and undressing the patient.

Standard:
1. The patient must be dressed or undressed with as much privacy as possible.
2. The procedure must be performed without undue discomfort or injury to the patient.

Learning Activities

1. Read pages 163-180, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp.216-224, Vol. I, 2nd Ed.), and/or pages 144-145 and 283-286, Being a Nursing Aide, 2nd Ed.

2. Observe a demonstration by your instructor.

3. Practice removing and replacing outer clothing of a classmate who is in a bed.

4. Practice removing and replacing outer clothing of a classmate who is in bed and who cannot assist.

5. Define the following terms:

   a. maturation
   b. distal
   c. proximal
   d. self-esteem
   e. supine
   f. contracture

6. Enter these terms and other new vocabulary in your vocabulary notebook. Check your definitions with your instructor.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module E: Care for the Newborn Infant

Task 1: CARRY INFANT

Performance Checklist

1. Wash hands.
2. Identify infant.
3. Lift infant from crib.
4. To carry infant using "football" carry:
   a. Support infant's head in palm of one hand.
   b. Support infant's back with the anterior portion of your forearm.
   c. Rest infant's hips on your hip.
   d. Extend infant's legs and feet between your chest and upper arm.
   e. Hold infant close to your body with elbow.
5. To carry infant using "upright" carry:
   a. Lift infant.
   b. Swing infant up to your shoulder level.
      (1) Front side of infant is lying against your upper chest.
      (2) The infant's chin should be at the level of the top of your shoulder.
      (3) Support head, neck and back continuously.

Test

Items Needed: Infant, doll or mannequin.

Task:
1. Use the "football" hold to carry the infant.
2. Use the "upright" hold to carry the infant.

Standard: The infant's head, neck and shoulders must be supported continuously.

Learning Activities

1. Read pages 351-352, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. and/or pages 203-205, Maternal and Child Health Nursing, 3rd Ed., Ingalls and Salerno.

2. Watch the filmstrips "Baby Care with a Touch of Love" and/or "Characteristics of the Newborn" by Trainex.

3. Watch a demonstration by your instructor.

4. Practice the carries with a doll or mannequin.

5. List any questions you might have about this task. Discuss these with your instructor before your return demonstration.

6. Perform a return demonstration for your instructor.

7. Practice the task in the hospital nursery, with an infant.

8. Have your instructor evaluate your performance.

9. List and discuss, in small groups, special safety precautions associated with infant carries.

Student Competency Sheet

Unit II: CARING FOR PERSONAL NEEDS OF PATIENTS

Module E: Care for the Newborn Infant

Task 2: BATHE INFANT

Performance Checklist

1. Wash hands.
2. Assemble bath tray.
3. Check room temperature (75°-80° F. or 23.9°-26.6° C).
4. Test bath water (105°-110° F. or 40.6°-43.3° C.).
5. Identify patient.
6. Place infant on a soft towel.
7. Wash, rinse and dry face, eyes, ears and nostrils.
8. Wash, rinse and dry scalp.
9. Undress infant.
10. Wash, rinse and dry neck, arms, chest and abdomen.
11. Wash, rinse and dry genitalia.
12. Wash, rinse and dry legs and feet.
13. Place infant on abdomen and wash, rinse and dry back and buttocks.
14. Diaper and dress infant.
15. Record procedure.
16. Report and record pertinent observations.

Test

Items Needed:
1. Infant or Chase baby doll
2. Bath tray

Task: Give the infant a sponge bath.

Standard:
1. Room temperature must be maintained at 75°-80° F. (23.9°-26.6° C.).
2. Water temperature must be maintained at 105°-110° F. (40.6°-43.3° C.).
3. All body surfaces must be checked for irritations.
4. All body surfaces must be cleaned and dried.

Learning Activities

1. Read page 33, Obstetrics for the Nurse, Anderson, or pages 199, 201-203, Maternal and Child Health Nursing, 3rd Ed., Ingalls and Salerno.

2. Observe a demonstration by your instructor.

3. Watch film, "Bathing a Newborn", by Johnson & Johnson, and/or "Bathing the Baby" by Trainex and "Bathing Baby" by Similac.

4. Practice the procedure in the laboratory, using a doll.

5. Complete the performance checksheet in the laboratory.

6. Bathe an infant in the hospital nursery.

7. Have your instructor evaluate your performance.

8. List observations that can be made during the baby's bath.

9. Practice recording such observations.

Name________________________
Date________________________
Unit II, Module E, Task 2

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Wash hands.		
2. Assemble bath tray.		
3. Check room temperature (75°-80° F. or 23.9°-26.6° C.).		
4. Test bath water (105°-110° F. or 40.6°-43.3° C.).		
5. Identify patient.		
6. Place infant on a soft towel.		
7. Wash, rinse and dry face, eyes, ears and nostrils.		
8. Wash, rinse and dry scalp.		
9. Undress infant.		
10. Wash, rinse and dry neck, arms, chest and abdomen.		
11. Wash, rinse and dry genitalia.		
12. Wash, rinse and dry legs and feet.		
13. Place infant on abdomen and wash, rinse and dry back and buttocks.		
14. Diaper and dress infant.		
15. Record procedure.		
16. Report and record pertinent observations.		

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module E: Care for the Newborn Infant

Task 3: CARE FOR UMBILICAL CORD

Performance Checklist

1. After cord has been clamped by physician, immediately after delivery, tie ligature around, or clamp, umbilical cord about one (1) inch from infant's abdomen.
2. Follow agency policy or attending physician's orders regarding antiseptic solution and dressing.
3. Apply dressing, if necessary.
4. Change dressing as necessary.
5. Use extreme care that umbilical cord does not become contaminated.
6. Report and record procedure and observations.

Test

Items Needed:
1. Newborn infant or Chase baby doll
2. Physician's orders or agency policy
3. Ligature
4. Clamp
5. Dressing

Task:
1. Care for the infant's umbilical cord using clamp.
2. Care for the infant's umbilical cord using ligature.

Standard: Care of the infant's umbilical cord must be in accordance with agency's policy.

Learning Activities

1. Read, as available, page 108, Maternal and Child Health Nursing, 3rd Ed., Ingalls and Salerno, and/or other sources selected by your instructor.

2. Watch "Delivery" filmstrip #409 by Trainex.

3. Observe delivery of an infant and how cord care is done in your institution.

4. Observe a demonstration by your instructor.

5. Practice the task using a doll or mannequin.

6. Perform a return demonstration for your instructor.

7. Assist with the task in the delivery room.

8. Have your instructor evaluate your performance.

Student Competency Sheet

Unit II. CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module E: Care for the Newborn Infant

Task 4: CARE FOR FEMALE GENITALIA

Performance Checklist

1. Assemble supplies.
2. Wash hands.
3. Identify patient.
4. Cleanse vulva.
    a. Use one cotton ball for each stroke.
    b. Cleanse from urethra toward anus.
5. Observe genitalia for abnormalities.
6. Record and report procedure and observations.

Test

Items Needed:
1. Newborn girl, or
2. Chase baby doll
3. Cotton balls
4. Cleansing materials

Task:
1. Cleanse the genitalia of a newborn girl.
2. Report unusual observations.

Standard:
1. Cleansing must progress from the urethra toward the anus.
2. Unusual observations must be accurately reported.

Learning Activities

1. Read, as available, pages 194-195, Maternal and Child Health Nursing, 3rd Ed., Ingalls and Salerno.

2. Watch "Health Care of the Normal Infant" #256 by Trainex.

3. Observe a demonstration by your instructor.

4. Practice the procedure on a mannequin or doll.

5. Perform a return demonstration for your instructor.

6. Practice the procedure on a newborn infant.

7. Have your instructor evaluate your performance.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module E: Care for the Newborn Infant

Task 5: DRESS CIRCUMCISION

Performance Checklist

1. Wash hands.
2. Assemble equipment and supplies.
3. Identify patient.
4. Remove diaper, observe for bleeding.
5. Cleanse area.
6. Apply sterile dressing to penis.
7. Put on diaper.
8. Tidy area.
9. Report and record procedure and observations.

Test

Items Needed:
1. Newly circumcised infant
2. Physician's orders
3. Cleansing materials
4. Dressing
5. Diaper

Task: Dress the infant's circumcision.

Standard: The dressing must be applied in accordance with the physician's orders.

Learning Activities

1. Read, as available, page 160 in Obstetrics for the Nurse, 1st Ed., Anderson, and/or pages 218-220 in Maternal and Child Health Nursing, 3rd Ed., by Ingalls and Salerno.

2. Observe a demonstration by your instructor in the laboratory or newborn nursery.

3. Observe the surgical procedure of circumcision, if possible.

4. Identify the reasons for sterile technique in this procedure and other special precautions to be followed.

5. Discuss these precautions in small groups and with your instructor.

6. Practice the procedure in the laboratory and newborn nursery. .

7. Have your instructor supervise and evaluate your performance in the newborn nursery.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module E: Care for the Newborn Infant

Task 6: DRESS INFANT

Performance Checklist

1. Place shirt, diaper and pins in convenient location.
2. Wash hands.
3. Identify patient.
4. To put on shirt:
    - a. Put your hand into shirt sleeve.
    - b. Using same hand, grasp infant's hand through sleeve.
    - c. Slip sleeve of shirt from your hand onto infant's arm.
    - d. Pull shirt sleeve up to infant's shoulder.
    - e. Gently lift infant enough to slide shirt under his/her body.
    - f. Repeat steps 4a-4d for second arm.
    - g. Adjust, snap or tie shirt.
5. To diaper infant:
    - a. Fold diaper.
    - b. Grasp both feet, lift infant's legs and buttocks and place diaper lengthwise under infant - top edge at hip level.
    - c. Bring bottom edge up between infant's legs.
    - d. Pin on both sides to diaper tab on shirt. (NOTE: Use caution not to stick infant when pinning diaper.)
    - e. Place your fingers on one hand between infant and diaper and pin with other hand.
    - f. Always lay pins in safe place, away from infant.

Test

Items Needed: 1. Infant, doll or mannequin
2. Shirt
3. Diaper
4. Pins

Task: Dress the infant.

Standard: The infant will be dressed without causing undue discomfort or injury to the infant.

Learning Activities

1. Read, as available, page 220 in Maternal and Child Health Nursing, 3rd Ed.

2. Observe a demonstration by your instructor.

3. Practice the procedure on a mannequin.

4. Practice the procedure on a newborn in the nursery.

5. Have your instructor evaluate your performance.

Student Competency Sheet

Unit II: CARING FOR PERSONAL NEEDS OF PATIENTS

Module E: Care for the Newborn Infant

Task 7: FEED INFANT

Performance Checklist

1. Wash hands.
2. Change baby's diaper.
3. Wash hands.
4. Identify baby.
5. Select proper formula.
6. Check size of nipple holes.
7. Select temperature of formula.
8. Test temperature of the formula.
9. Sit comfortably, holding baby to feed, supporting head and neck.
10. Feed baby.
11. Hold bottle at an angle which avoids air bubbles.
12. Burp infant (frequency depends on type of bottle).
13. Check diaper; change, if necessary.
14. Wash hands.
15. Return baby to crib, placing baby on side or abdomen to prevent aspiration.
16. Raise crib sides.
17. Clean bottle.
18. Record feeding.

Test

Items Needed:

1. Infant, doll
2. Diapers
3. Lotion and/or powder
4. Bottle (with nipple) and formula
5. Assignment sheet

Task: Feed the baby.

Standard:

1. The baby must be held securely.
2. The prescribed formula must be fed to baby.
3. The baby must be positioned in the crib to prevent aspiration.

Learning Activities

1. Read pages 350-353, Nursing Skills for Allied Health Services, Vol. I, 1st Ed.

2. Watch "Baby Care with a Touch of Love" and "Bottle Feeding" (#252) - Trainex.

3. Practice the task in the laboratory.

4. Practice the task in the hospital nursery.

5. Discuss, in small groups and with your instructor, special observations that can be made during feeding time.

6. Have your instructor evaluate your performance in the newborn nursery. Make note of his/her suggestions.

7. Complete the written evaluation for this task. Your answers must be 85% accurate.

8. Have your instructor check your answers.

Student Competency Sheet

UNIT II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module E: Care for the Newborn Infant

Task 8: IDENTIFY NEWBORN USING BRACELET, IMPRINTS, ETC.

Performance Checklist:

NOTE: Agency policies and procedures vary. Follow the procedures established by your agency. The following should serve as a guideline, however, and would normally be accomplished before the infant leaves the delivery room.

1. Wash hands.
2. Apply identification in two (2) places, i.e., bracelet and necklace. (Identification must include parent's surname.)
3. Obtain footprints of both feet on appropriate form.
   a. Cleanse infant's feet according to agency policy.
   b. Wash your hands.
   c. Ink bottom of infant's foot.
   d. Place heel or inked foot on chart and "walk" with heel-to-toe motion.
   e. Clean ink from infant's foot.
   f. Repeat procedure for other foot.
4. Obtain mother's thumb prints (both thumbs) on same chart.
5. Record procedure.

Test

Items Needed:
1. Newborn infant
2. Agency policy
3. Bracelet
4. Necklace
5. Ink pad
6. Identification chart
7. Cleansing materials

Task:
1. Identify the newborn using bracelets, imprints, etc. according to agency policy.
2. Obtain infant's and mother's prints.

Standard:
1. Chart will be properly completed.
2. Imprints must be clear, without smudging.
3. Necklaces, braclets must be securely fastened.

Learning Activities

1. Attend lecture/demonstration using infant mannequin.

2. Read
   a. Pages 175-176, "Identification," Basic Maternity Nursing, Hamilton, 3rd Ed
   b. Page 346, "Identification Methods," Maternity Nursing, Reeder.
   c. Page 201, "Identification and Observation," Maternal and Child Health Nursing, Ingalls and Salerno.

3. Read agency procedure manual, "Identification of Newborn."

4. Practice performance using infant mannequin.

5. Identify equipment needed and demonstrate the task for fellow students.

6. Discuss, in small groups, the importance of proper identification of the newborn. Identify significant times in daily nursing care when special precautions should be taken to check and double check proper identification.

7. Practice performance in agency or hospital setting with instructor's supervision.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module E: Care for the Newborn Infant

Task 9: WEIGH AND MEASURE INFANT

Performance Checklist

1. Wash hands.
2. Identify infant.
3. To weigh infant:
    a. Line scale with clean diaper, paper, blanket, towel, etc.
    b. Balance scale.
    c. Place infant on scale.
    d. Determine weight. (NOTE: Weight is usually recorded in grams on the infant's chart and converted to pounds and ounces for mother's benefit.)
    e. Record weight.
4. To measure infant:
    a. Place infant, lying on back, on table.
    b. Straighten body and legs.
    c. Measure from heel to top of head.
    d. Record measurement.

Test

Items Needed: 1. Infant 2. Scale liner 3. Infant scale 4. Measuring instrument

Task:
1. Weigh the infant.
2. Convert the weight from grams to pounds and ounces.
3. Measure the infant's length.
4. Record the height and weight.

Standard:
1. The infant's safety must be assured throughout the procedure.
2. The exact weight must be determined.
3. The weight conversion from grams to pounds and ounces must be accurate.
4. The exact height (length) must be recorded accurately.

Learning Activities

1. Read:
    a. Pages 177-178, "Weighing and Measuring," Basic Maternity Nursing.
    b. Page 689, "Conversion Table for Weight of Newborn," Maternity Nursing.
    c. "Conversion of Pounds and Ounces to Grams," Maternal Child Health Nursing (inside back cover).

2. Attend a demonstration of weighing and measuring newborn in agency or laboratory setting, according to agency policy.

3. Observe and manipulate equipment used in weighing an infant.

4. Practice performance with infant mannequin.

5. Demonstrate this task with infant mannequin, for fellow students.

6. Have your instructor evaluate your performance in a simulated situation.

7. Practice weighing newborn in agency setting with supervision of instructor.

8. Have your instructor supervise this task in the hospital or agency setting until the standards of the task are met.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module E: Care for the Newborn Infant

Task 10: SUCTION INFANT'S RESPIRATORY PASSAGE

Performance Checklist

1. Wash hands.
2. Assemble equipment and supplies.
3. Insert catheter to pharynx.
4. Apply gentle suction to remove all mucus.
5. Remove catheter.
6. Position infant on abdomen with head lowered.
7. Observe infant's respiration closely.
8. Report and record procedure and pertinent observations.

Test

Items Needed: 1. Infant
2. Suction Equipment

Task: Suction the infant's respiratory passage.

Standard: 1. All mucus must be removed.
2. Mucous membranes should not be injured.
3. Adequate respiratory function must be maintained.

Learning Activities

1. Read page 174, "Clearing the Airway," Basic Maternity Nursing and/or page 592, "Removal of Mucus," Maternity Nursing.

2. Attend lecture/demonstration using infant mannequin.

3. Identify equipment needed according to infant size, condition, etc., and demonstrate utilization of it.

4. View, as available, the following filmstrips:
"Respiratory Emergencies" - Career Aids
"Normal Breath Sounds" - Trainex #425
"Pharyngeal Suctioning" - Trainex #270
"Respiratory Distress Syndrome in the Newborn" - Trainex

5. In small groups, discuss the filmstrips available to you. Identify signs of respiratory distress in newborns. Summarize your findings and check the list with your instructor.

6. Practice performance using infant mannequin.

7. Outline steps for resuscitation and notifying emergency personnel within the policies of your agency or teaching hospital.

8. Have your instructor evaluate your performance in a simulated situation. Note suggestions and repeat practice and evaluation in areas of difficulty.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module E: Care for the Newborn Infant

Task 11: IRRIGATE EYES WITH SILVER NITRATE

Performance Checklist

1. Assemble supplies
2. Wash hands.
3. Identify patient.
4. Using sterile cotton balls and sterile water, cleanse eyelids.
5. Instill 1% (one percent) solution of silver nitrate into both eyes.
   a. Pull lower eyelid down.
   b. Instill two (2) drops of 1% solution of silver nitrate into conjunctive sac.
   c. Repeat steps 5a and 5b for second eye.
6. Irrigate both eyes one to two minutes after the silver nitrate solution has been instilled.
7. Provide for patient's comfort.
8. Record procedure.

Test

Items Needed:
1. Newborn infant or infant mannequin.
2. Sterile cotton balls.
3. Sterile water.
4. 1% solution of silver nitrate.

Task:
1. Instill a 1% solution of silver nitrate into both eyes.
2. Irrigate both eyes.

Standard:
1. The irrigation must be performed according to agency policy.
2. Aseptic techniques must be maintained.

Learning Activities

1. Read:
   a. Pages 176-177, "Prophylaxis," Basic Maternity Nursing.
   b. Pages 344-345, "Care of the Eyes," Maternity Nursing.
   c. Page 108, "Immediate Care," Maternal and Child Health Nursing.

2. Attend lecture/demonstration using infant mannequin.

3. Review the anatomy of the eye.

4. Identify equipment needed and demonstrate the utilization of equipment for fellow students.

5. Practice performance using infant mannequin.
6. Perform a return demonstration for your instructor in a simulated situation.
7. Have your instructor supervise and evaluate your performance of this task in the hospital setting.

Student Competency Sheet

Unit II: CARING FOR PERSONAL NEEDS OF PATIENTS

Module F: Use of Supports for Locomotion and Traction

Task 1: ASSIST IN PUTTING ON OR REMOVING BRACES OF A PATIENT

Performance Checklist

1. Wash hands.
2. Identify Patient.
3. Explain procedure.
4. Position patient for brace application.
5. Apply brace.
6. Check for pressure areas.
7. Report pain or discomfort.
8. Remove back brace and store appropriately.
9. Check for reddened areas.
10. Leave patient comfortable.

Test

Items Needed:
1. Patient
2. Back brace
3. Long leg Brace
4. Short leg brace
5. Neck brace

Task: Apply and remove each of the four (4) different types of braces.

Standard: Braces must be applied and removed without undue discomfort or injury to the patient.

Learning Activities

1. Read pages 296-300, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 179-183, Vol. I, 2nd Ed.). After reading this section on braces, you should be able to answer question 5 (1st Ed.), question 14 (2nd Ed.). Check your answer on page 304 (1st Ed.), page 185 (2nd Ed.).

2. In the skill laboratory, using another student as your patient, practice applying and removing the following braces:

   a. Back brace
   b. Long leg brace
   c. Short leg brace
   d. Neck brace

3. When you feel you have had adequate practice in the application and removal of the braces, ask your instructor to observe your performance.

Student Competency Sheet

Unit II: CARING FOR PERSONAL NEEDS OF PATIENTS

Module F: Use of Supports for Locomotion and Traction

Task 2: ASSIST PATIENT TO DANGLE

Performance Checklist

1. Wash hands.
2. Assemble designated supplies.
3. Identify patient.
4. Explain the procedure to the patient.
5. Move the patient to the proximal side of the bed.
6. Adjust the bed to the low position or provide a footstool.
7. Gradually raise the headrest to approximately 45°.
8. Raise the patient to a sitting position with one hand on his proximal shoulder and the other under his distal axilla.
9. Continue supporting the patient's shoulder and place your other hand under the patient's distal knee, swinging patient's legs off the bed while pivoting patient's body.
10. Check the patient's pulse.
11. Instruct patient to swing legs.
12. Dress the patient in robe and slippers for comfort and modesty.
13. Fluff the pillow while patient is dangling feet.
14. Dangle for designated length of time, remaining with the patient throughout (should faintness occur, return patient to bed position, and report to supervisor immediately).
15. Remove robe and slippers when patient is ready to lie down.
16. Return patient to bed position.
17. Recheck patient's pulse.
18. Make the patient comfortable.
19. Record and report observations and procedure.

Test

Items Needed:
1. Patient
2. Bed
3. Robe and slippers
4. Pillow

Task: Assist a patient to dangle from a supine position.

Standard:
1. Good body techniques must be used in moving the patient.
2. The patient's body must be supported and good body alignment maintained.
3. The patient must be attended at all times.

Learning Activities

1. Read pages 260-262, Nursing Skills for Allied Health Services, Vo. I, 1st Ed. (pp. 141-143, Vol. I, 2nd Ed.). Answer questions Q and R (1st Ed.), questions 17 and 18 (2nd Ed.). Check your answers on page 269 (1st Ed.), p. 150 (2nd Ed.).

2. Watch the Trainex filmstrip, "Lifting and Moving Patients."
3. In the skill laboratory, practice assisting a patient to dangle.
4. When you feel you are ready, ask your instructor to check your performance.

Student Competency Sheet

Unit II: CARING FOR PERSONAL NEEDS OF PATIENTS

Module F: Use of Supports for Locomotion and Traction

Task 3: ASSIST PATIENT IN STANDING

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Dress patient appropriately.
4. Place bed in low position or provide a footstool.
5. Elevate head of bed unless it is not advised.
6. Allow patient to reach sitting position and dangle unless it is not advised.
7. Take pulse.
8. Grasp patient under arm closest to nursing assistant with one hand and place other hand around patient's back using good body mechanics.
9. Allow patient to come to standing position, giving support with knees.
10. Observe patient for change in skin color or pulse and report.
11. Return to bed in same manner, leaving patient comfortable.
12. Report and record observations and procedure.

Test

Items Needed:	1.	Patient
	2.	Bed
Task:	1.	Assist a patient to a standing position from a supine position.
	2.	Assist a patient to a standing position from a sitting position.
Standard:	1.	The patient must be adequately supported at all times.
	2.	Good body mechanics must be observed.

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1. Review pages 260-265, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 141-145, Vol. I, 2nd Ed.). Give particular attention to Step 5 on page 264 (1st Ed.), page 145 (2nd Ed.).

2. In the skill laboratory, practice assisting a patient to stand.

3. When you feel you are ready, ask your instructor to check your performance.

4. Identify, in small groups, and list pertinent observations that could be made when ambulating a patient for the first time.

Student Competency Sheet

Unit II: CARING FOR PERSONAL NEEDS OF PATIENTS

Module F: Use of Supports for Locomotion and Traction

Task 4: ASSIST PATIENT IN WALKING

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Take pulse and respiration, if appropriate.
5. Place bed in low position, or provide footstool.
6. Elevate head of bed.
7. Dangle patient.
8. Help the patient to a standing position using good body mechanics.
9. Align the patient in good body position, correcting his posture.
10. Walk with the patient, giving necessary support.
    a. To give minimal support: the patient holds your elbow or hand with his/her hand.
    b. To give moderate support: hold the patient's arm with your hand.
    c. To give maximal support: have another person help you by giving support on opposite side.
11. Observe for any unusual reactions.
12. Return to bed.
13. Take pulse and respiration, if appropriate.
14. Leave patient comfortable and in good alignment.
15. Report observations of change in skin color and condition or pulse rate and complaints of pain or discomfort.
16. Report procedure and observations.
17. The health worker must maintain good body alignment and balance throughout the procedure.

Test

Items Needed:	1. Patient 2. Bed 3. Footstool
Task:	Assist the patient to walk.
Standard:	1. The patient must be adequately supported at all times. 2. Good body mechanics must be observed.

Learning Activities

1. Read pages 262-267, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 143-148, Vol. I, 2nd Ed.). Answer questions S-Y (1st Ed.), questions 19-25 (2nd Ed.). Check your answers on page 269 (1st Ed.), p. 150 (2nd Ed.).

2. Review, if necessary, the Trainex filmstrip, "Lifting and Moving Patients" and "Patient Transfers and Ambulation" by Train-aide. If these filmstrips are not available, ask your instructor if there are any others to view.

3. In the skill laboratory, practice assisting a patient to walk.

Student Competency Sheet

Unit II: CARING FOR PERSONAL NEEDS OF PATIENTS

Module F: Use of Supports for Locomotion and Traction

Task 5: ASSIST PATIENT IN WALKER USE

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Place bed in low position or provide a footstool.
5. Elevate head of bed gradually.
6. Get patient into a sitting position and dangle unless it is not advised.
7. Dress in robe and slippers.
8. Position walker with open end toward patient.
9. Steady the walker with hands and one foot.
10. Allow patient to stand, using the rails of the walker for support.
11. Position back support of walker, if appropriate.
12. Check and adjust the height of the walker as required.
13. Have patient's elbows flexed approximately 30°.
14. Allow patient to walk slowly, using the walker for support. Caution patient to take small steps.
15. Return patient to bed.
16. Leave patient comfortable and in good body alignment.
17. Report procedure and observations.

Test

Items Needed:
1. Patient who needs support in walking
2. Bed
3. Footstool
4. Walker

Task: Assist the patient to use a walker.

Standard: The patient will not slip or fall.

Learning Activities

1. Read pages 289-291, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 171-173, Vol. I, 2nd Ed.). Answer questions J-M (1st Ed.), questions 6-9 (2nd Ed.). Check your answers on page 304 (1st Ed.), 185 (2nd Ed.).

2. Watch, as available, filmstrips "Transfer Activities and Ambulation" by Trainex #400 and/or "Patient Transfers and Ambulation" by Train-aide.

3. In the skill laboratory, practice assisting a patient into a walker. Allow the patient to stand and then walk slowly.

4. When you feel you have had adequate practice, ask your instructor to check your performance.

5. Identify special safety precautions to follow when practicing this task.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module F: Use of Supports for Locomotion and Traction

Task 6: ASSIST PATIENT IN USING A CANE

Performance Checklist

1. Obtain the necessary equipment. Check to make sure the cane has a good rubber tip.
2. Wash hands.
3. Identify patient and explain the procedure.
4. Measure to determine the desired length of the cane.
   a. The curve of the handle should fit the palm of the patient's hand, with the elbow flexed at a 30° angle.
   b. The cane should be at a point of about six (6) inches out from patient's foot on the affected side.
5. Assist the patient to stand erect.
6. Instruct the patient to extend the cane to the floor at a point of about six (6) inches out from foot on the affected side.
7. Assist patient while advancing foot on unaffected side.
8. Assist patient while simultaneously advancing foot and cane on affected side.
9. Provide for safety of patient.
10. Record and report observations.

Test

Items Needed:
1. Patient
2. Bed or chair
3. Cane with rubber suction tip

Task: Assist patient to walk with a cane.

Standard: Your assistance must provide adequate instruction and prevent the patient from slipping or falling.

Learning Activities

1. Read "Use of Cane", page 303, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (p. 184, Vol. I, 2nd Ed.).

2. View any filmstrips your instructor may have available.

3. In the skill laboratory, practice using a cane. When you feel you have mastered the technique, instruct a patient (another student) in using a cane.

4. When you feel you are ready, ask your instructor to check your performance.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module F: Use of Supports for Locomotion and Traction

Task 7: ASSIST PATIENT IN CRUTCH WALKING

Performance Checklist

1. Obtain the proper equipment.
    a. Crutches should have no splinters, breaks or bends.
    b. The crutch tip should be in good condition.
    c. The axillary pad bar should be installed, if required.
2. Wash hands.
3. Identify the patient and explain the procedure.
4. Ask the patient to lie flat on the bed.
5. Measure to determine the length of crutch required.
    a. The crutch tip should be approximately six (6) to eight (8) inches from the side of the heel.
    b. There should be approximately two (2) fingers' distance between the axillary bar and the axilla.
    c. The elbows should be flexed approximately 30°.
6. Adjust the position of the hand-bar and the length of the shaft as required.
7. Demonstrate for your instructor the three (3)-point gait.
    a. Conditions for use - full weight bearing on one leg, partial or no weight bearing on the other.
8. Demonstrate for your instructor the four (4)-point gait.
    a. Condition for use - partial weight bearing on both legs.
9. Demonstrate for your instructor the two (2)-point gait.
    a. Condition for use - partial weight bearing on both legs.
10. Demonstrate to the patient the gait they will use.
11. Assist the patient into appropriate clothing (well fitting clothing and hard sole shoes).
12. Allow the patient to dangle.
13. Assist patient to a standing position.
14. Give the crutches to the patient checking to make sure weight is on the hands with no pressure on axilla.
15. Walk behind the patient to give support as needed.
16. Help the patient to return to bed.
17. Provide for the patient's comfort.
18. Record and report the procedure and necessary observations.

Test

Items Needed: 1. Patient
2. Pair of crutches

Task: Assist a patient to crutch walk.

Standard: 1. The proper sized crutches must be used.
2. There must be no pressure on the axilla.
3. The patient must not slip or fall.

Learning Activities

1. Read pages 291-296, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 173-179 Vol. I, 2nd Ed.). Answer questions N-Q (1st Ed.), questions 10-13 (2nd Ed.). Check your answers on page 304 (1st Ed.), page 185 (2nd Ed.).
2. Watch the filmstrip, "Teaching Crutch Walking" (PC 175) by Trainex.
3. In the skill laboratory, practice adjusting the crutches to the proper length. You will need another student to be the patient.
4. Practice identification of the two, three and four-point gait.
5. Practice performing the two, three and four-point gait.
6. Role play a patient-care situation of teaching a patient how to use crutches properly. Participate as a patient and a member of the nursing team.
7. When you feel you have had adequate practice, ask your instructor to observe your performance of this task.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module F: Use of Supports for Locomotion and Traction

Task 8: APPLY OR REMOVE SKIN TRACTION

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Wash hands.
5. Position patient. Check for proper body alignment.
6. Apply traction devices to patient's skin.
7. Attach traction cord to traction devices.
8. Apply prescribed weight to cord.
   CAUTION: Gently lower weight to apply traction.
9. Reverse procedure to remove traction.
   CAUTION: Never remove or change weights without an order.
10. Recheck for proper body alignment.
11. Make patient as comfortable as possible. Provide for patient's comfort.
12. Record procedure and pertinent observations.

Test

Items Needed:
1. Patient
2. Bed
3. Physician's order
4. Tension devices
5. Traction cord
6. Weights

Task: Apply and remove skin traction.

Standard:
1. The patient's body alignment must be maintained and supported.
2. The prescribed weight must be applied and removed slowly. Avoid undue discomfort or harm to the patient.

Learning Activities

1. Watch Trainex filmstrip #441, "Care of the Patient in Traction".

2. Read pages 230-232, Nursing Skills for Allied Health Services, Vol. I, 1st ed. (pp. 454-457, Vol. II, 2nd ed.).

3. Identify three reasons that traction may be used to treat musculo-skeletal conditions. Review your answers with your instructor.

4. In the learning laboratory, assemble necessary materials and practice applying traction devices to a mannequin.

5. Complete the performance checksheet, in the laboratory, with the mannequin as the patient.

6. When the situation is available in the hospital setting, your instructor will assist you in the application of skin traction.

Name________________________
Date________________________
Unit II, Module F, Task 8

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Check physician's orders.		
2. Assemble equipment and supplies.		
3. Identify patient and explain procedure.		
4. Wash hands.		
5. Position patient. Check for proper body alignment.		
6. Apply traction devices to patient's skin.		
7. Attach traction cord to traction devices.		
8. Apply prescribed weight to cord. CAUTION: Gently lower weight to apply traction.		
9. Reverse procedure to remove traction. CAUTION: Never remove or change weights without an order.		
10. Recheck for proper body alignment.		
11. Make patient as comfortable as possible. Provide for patient's comfort.		
12. Record procedure and pertinent observations.		

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module F: Use of Supports for Locomotion and Traction

Task 9: POSITION TROCHANTER ROLLS AND/OR SANDBAGS

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Identify patient and explain equipment.
4. Wash hands.
5. Position patient.
6. To position sandbags or trochanter rolls:
    a. Place firmly against part to be supported.
    b. Keep body part straight and in proper alignment.
7. Provide for patient's comfort.
8. Tidy area.
9. Record procedure.

Test

Items Needed:
1. Bed patient
2. Physician's order
3. Sandbags or trochanter
4. Footboard

Task: Position the sandbags or trochanter rolls to support or immobilize a designated body part.

Standard: The designated body part must be supported in proper alignment to prevent its rotation.

Learning Activities

1. Watch a demonstration by your instructor.

2. Watch Lippincott film loop, "Prevention of External Rotation - Trochanter Roll."

3. Watch the Trainex filmstrip, "Positioning to Prevent Complications."

4. Read pages 314-318, Nursing Skills for Allied Health Services, Vol. I, 1st ed. (pp. 102-106, Vol. I, 2nd ed.). Answer questions F-I (1st ed.), questions 4-7, (2nd ed.). Check your answers on page 335 (1st ed.), page 123 (2nd ed.).

5. In the skill laboratory, practice positioning the sandbags and trochanter rolls to support or immobilize the body part designated by your instructor.

6. When you feel you are ready, ask your instructor to check your performance.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module G: Moving and Transporting Patients

Task 1: TRANSFER A HELPLESS PATIENT TO AND FROM A STRETCHER USING A TRANSFER SHEET

Performance Checklist

1. Obtain a stretcher.
2. Wash hands.
3. Identify the patient and explain the procedure.
4. Provide for privacy.
5. Position and prepare the patient.
6. Position the stretcher next to the bed and lock the wheels.
7. Transfer the patient onto the stretcher by using the lifting sheet.
8. Make the patient comfortable.
9. Raise the siderails or fasten the safety belt.
10. Transfer the patient onto the bed from the stretcher by using the lifting sheet.
11. Use good body mechanics at all times.
12. Leave the patient comfortable and in good body alignment.
13. Raise the siderails.
14. Replace equipment.
15. Report and record the procedure as appropriate.

Test

Items Needed:
1. Patient
2. Stretcher
3. Bed
4. Transfer sheet
5. Two to four partners

Task: To transfer a helpless patient to and from a stretcher using a transfer sheet.

Standard:
1. The patient must be moved in a safe manner consistent with the patient's condition.
2. Good body mechanics must be observed.

Learning Activities

1. Read pages 163-165, Nursing Skills for Allied Health Services, Vol. I, 2nd Ed.

2. Watch the Trainex filmstrips, "Lifting and Moving Patients" and/or "Transfer Activities and Ambulation" #400.

3. Attend a demonstration given by your instructor.

4. In the skill laboratory, practice moving a patient, using a transfer sheet, to and from the stretcher. You will need the assistance of two (2) to four (4) partners (depending on the size and condition of the patient.)

5. When you feel you are ready ask your instructor to check your performance.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module G: Moving and Transporting Patients

Task 2: TRANSFER A PATIENT TO AND FROM A STRETCHER USING A THREE-MAN LIFT

Performance Checklist

1. Wash hands.
2. Discuss with the team members how the transfer will be made, including the count or signals, before entering the room.
3. Identify patient and explain procedure.
4. Place stretcher at 45° angle to bed with head of stretcher near foot of bed. Lock stretcher.
5. Position the team.
   a. You stand near the patient's head with one arm under the patient's neck and one arm under patient's back.
   b. Second person stands opposite the patient's hips, with one arm under the patient's back and the other arm under the thighs.
   c. Third person stands at the patient's thighs with one arm under patient's legs.
6. Give signal to team members to:
   a. Move the same foot forward and flex their hips and knees.
   b. Slowly and carefully straighten their legs and lift the patient and turn patient toward their chest.
   c. Make a slow turn and walk to the stretcher.
   d. Gently place the patient on the stretcher.
7. Cover patient with a blanket and raise the siderails or fasten safety straps.
8. Return the patient to the bed using the same procedure.
9. Leave the patient comfortable and in good body alignment.
10. Return equipment to the storage area.
11. Report and record the procedure as appropriate.

Test

Items Needed:
1. Patient
2. Stretcher
3. Two partners
4. Bath blanket

Task: Assume lead role in transferring a patient to and from a stretcher, using the three (3)-man lift.

Standard:
1. Patient must be moved in a safe manner consistent with the patient's condition.
2. Good body mechanics must be observed.

Learning Activities

1. Read pages 6-31 to 6-33, Being a Nursing Aide, 1st Ed.
2. Watch the filmstrips by Trainex, "Lifting and Moving Patients" and "Transfer Activities and Ambulation," and/or "Patient Transfers and Ambulation" by Train-aide Corporation.
3. In the skill laboratory, practice lifting a patient from the bed to the stretcher. You will need two partners for this procedure. Ask your instructor to be present during your practice.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module G: Moving and Transporting Patients

Task 3: TRANSPORT PATIENT BY STRETCHER

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Transfer patient from bed to stretcher.
4. Place safety straps across patient or raise siderails, being sure hands and arms do not protrude.
5. Walk at head of stretcher.
6. Proceed with caution and protect patient's head.
7. Secure elevator door.
8. Enter elevator foot end first and stand at patient's head.
9. Leave elevator by pulling stretcher head first.
10. Approach corners on right hand side of hallway; proceed slowly and cautiously.

Test

Items Needed:
1. Patient
2. Stretcher
3. Elevator

Task: Transport a patient by stretcher through corridors, onto an elevator and around corners.

Standard: The patient must be transported safely without undue discomfort or injury.

Learning Activities

1. Read page 4-12 and 4-13, Being a Nursing Aide, 1st Ed. (p. 119-120, 2nd Ed.).

2. Review technique for transferring a patient from the bed to a stretcher.

3. In the skill laboratory, assist a fellow student to a stretcher and transport them through corridors, onto an elevator and around corners.

4. When you feel you are ready, ask your instructor to check your performance.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module G: Moving and Transporting Patients

Task 4: TEACH PATIENT TO TRANSPORT SELF IN WHEELCHAIR

Performance Checklist

1. Obtain the appropriate equipment.
2. Check the equipment for proper working condition.
   a. Brakes.
   b. Wheels and tires.
   c. Upholstery.
3. Wash hands.
4. Identify the patient and explain the procedure.
5. Demonstrate and describe the correct techniques for using the wheelchair to the patient.
   a. Proper use of brakes (setting and releasing).
   b. Positioning the footrest.
   c. Propelling the chair in a straight line.
   d. Turning corners.
   e. Passing through an ordinary doorway or one equipped with an automatic closing device.
6. Provide the patient with an opportunity to practice under supervision the techniques of propelling the wheelchair.
7. Encourage the patient to utilize the proper method of manipulating the wheelchair.
8. Chart the procedure.

Test

Items Needed: 1. Patient
2. Wheelchair

Task: Instruct the patient in the proper techniques for using a wheelchair after performing this procedure yourself.

Standard: 1. The procedure must be performed observing all safety precautions.
2. Good body mechanics must be observed at all times.

Learning Activities

1. Read pages 284-285, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 165-166, Vol. I, 2nd Ed.).

2. Answer question E, 1st Ed., (question 5, 2nd Ed.), and check your response on page 304, 1st Ed., (page 185, 2nd Ed.).

3. In the skill laboratory, practice using a wheelchair.

4. Teach another student the correct usage of the wheelchair.

5. When you feel you are ready, ask your instructor to observe your performance of using the wheelchair yourself and teaching the patient to use the wheelchair.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module G: Moving and Transporting Patients

Task 5: ASSIST A PATIENT (WHO CAN STAND) TO AND FROM A WHEELCHAIR

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure to the patient.
4. Check wheelchair for mechanical defects.
5. Bring appropriate size wheelchair to bedside.
6. Position wheelchair at foot of bed facing head of bed, set the brakes and raise the footrest.
7. Place bed in low position or use a footstool as needed.
8. Allow patient to dangle.
9. Dress the patient in robe and slippers.
10. Assist patient to a standing position.
11. Have patient pivot and lower body into the wheelchair.
12. Reverse the procedure to move patient from wheelchair to the bed.
13. Leave patient comfortable and in good alignment.
14. Replace equipment.
15. Report procedure and any problems or symptoms encountered.

Test

Items Needed:
1. Patient
2. Bed
3. Wheelchair

Task: Transfer a patient who can stand to and from a wheelchair.

Standard:
1. The patient must be moved to and from a wheelchair in a safe manner consistent with the patient's condition.
2. Good body mechanics must be observed.

Learning Activities

1. Read pages 285-287, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 167-168, Vol. I, 2nd Ed.).

2. Read pages 6-25 and 6-26, Being a Nursing Aide, 1st Ed. (pp. 111-114, 2nd Ed.).

3. Review the filmstrip, "Lifting and Moving Patients" by Trainex.

4. In the skill laboratory, practice transferring a patient who can stand to and from a wheelchair.

5. When you feel you are ready, ask your instructor to check your performance.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module G: Moving and Transporting Patients

Task 6: MOVE A PATIENT (WHO CANNOT STAND) TO AND FROM A WHEELCHAIR

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Check wheelchair for mechanical defects.
5. Place wheelchair near head of bed, and put on brakes.
6. Obtain the help of two other people.
7. Move the patient to near side of bed.
8. Have assistants take their places: one at head and shoulders, one at hips and one at feet.
9. Using good body mechanics, at the count of three (3), transfer the patient into the wheelchair with all helpers moving together.
10. Make patient comfortable and cover legs with blanket.
11. Transfer the patient from wheelchair to bed by reversing the above procedure.
12. Place patient in good body alignment.
13. Report procedure and any incidents or observations.

Test

Items Needed:
1. Patient
2. Wheelchair
3. Bed
4. Blanket
5. Two partners

Task: Assist in transferring a patient (who cannot stand) to and from a wheelchair.

Standard:
1. The patient must be moved to and from a wheelchair in a safe manner consistent with the patient's condition.
2. Good body mechanics must be observed.

Learning Activities

1. Read pages 287-288, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 170-171, Vol. I, 2nd Ed.).

2. Read pages 6-27 and 6-28, Being a Nursing Aide, 1st Ed. (pp. 114-115, 2nd Ed.).

3. In the skill laboratory, practice transferring a patient (who cannot stand) to and from a wheelchair. You will need two (2) partners to assist you. (Depending on the condition and size of the patient, you may need more than two.)

4. When you feel you are ready, ask your instructor to check your performance.

Student Competency Sheet

Unit II: CARING FOR THE PERSONAL NEEDS OF PATIENTS

Module G: Moving and Transporting Patients

Task 7: TRANSPORT PATIENT BY WHEELCHAIR

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Transfer to wheelchair.
5. Approach closed doorway backwards.
6. Use one hand to open door.
7. Pull chair through backwards.
8. Turn wheelchair to forward after getting through door.
9. Pull wheelchair onto elevator backwards.
10. Turn chair around and leave elevator pulling wheelchair backwards.
11. Make a right turn by exerting more pressure on the left handle; reverse procedure for left turn.
12. Make all turns carefully and smoothly to avoid stress or danger to the patient.

Test

Items Needed:
1. Patient
2. Wheelchair
3. Elevator

Task: Transport a patient by wheelchair through a doorway, onto an elevator and around corners.

Standard:
1. The procedure must be performed in a manner which is safe and consistent with the patient's condition.
2. The procedure must be performed without damage to equipment.

Learning Activities

1. Read pages 284-285, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 165-167, Vol. I, 2nd Ed.). Review the procedural skills for helping a patient into the wheelchair.

2. In the skill laboratory, practice transporting a patient in the wheelchair.

3. Participate in practice sessions, as a "patient." Identify comfort measures that might be helpful for the patient being transported in a wheelchair.

4. When you feel you are ready, ask your instructor to check your performance of this task.

Student Competency Sheet

Unit II: CARING FOR PERSONAL NEEDS OF PATIENTS

Module G: Moving and Transporting Patients

Task 8: USE MECHANICAL LIFTER

Performance Checklist

1. Identify patient and explain procedure.
2. Position wheelchair and apply the brakes.
3. Position mechanical lifter.
4. Place sling straps under patient's thighs and back.
5. Fasten sling straps to the corresponding hooks on the lifting bar.
6. The worker operating the lifting bar must release the hydraulic pressure valve and pump the handle to raise the lifting bar until patient's body clears bed.
7. Close the hydraulic pressure valve.
8. Roll mechanical lifter to wheelchair.
9. Second worker guides patient in the sling.
10. Place patient in a sitting position over the seat of the wheelchair.
11. Release hydraulic pressure valve to lower the patient to the seat.
12. Unhook sling straps and remove from beneath patient.
13. Provide for patient's comfort and safety.
14. Record procedure and pertinent observations.

Test

Items Needed:
1. Bed patient
2. Wheelchair
3. Mechanical lifter
4. A co-worker

Task: Use the mechanical lifter to transfer the patient from his/her bed to a wheelchair.

Standard: The patient's body must be aligned and supported to prevent slipping or falling.

Learning Activities

1. Read pages 161-163 and 168-170, Nursing Skills for Allied Health Services, Vol. I, 2nd Ed. (1st Ed., Vol. I, pages 281-283 and 301-302).

2. View filmstrips:
   "Lifting and Moving Patients" - Trainex PC 375
   "Use of Patient Lifters" - Trainex #123

3. Practice use of mechanical lifter using classmate as patient.

4. Discuss with classmates, how it feels to be suspended by a mechanical lifter and explore ways to reassure the patient.

5. Have your instructor evaluate your performance of this task.

UNIT III

ASSISTING WITH NUTRITION AND ELIMINATION NEEDS OF PATIENTS

Terminal Objectives

Upon completion of the modules in this unit, you will:

- Observe, measure and report food and fluid intake.
- Use correct technique to distribute drinking water and assist with serving or feeding the adult or child.
- Observe, measure and report output of patient.
- Assist a patient to use a bedside commode or bathroom, a bedpan or urinal.
- Assist with removing or remove fecal impaction.

Student Competency Sheet

Unit III: ASSISTING WITH NUTRITION AND ELIMINATION NEEDS OF PATIENTS

Module A: Intake

Task 1: OBSERVE, MEASURE AND REPORT FOOD AND FLUID INTAKE

Performance Checklist

1. Obtain list of measurements of common containers used in the hospital.
2. Identify those items which are considered fluids.
3. Pour fluid up to the container's capacity.
4. Identify patient.
5. Inform patient of intake-output procedure.
6. Distribute food and fluids.
7. Observe amount of fluid left in container after patient has finished drinking.
8. Record the difference between the container's capacity and amount left in container.
9. Record on worksheet the total amount taken after each meal and after each fluid intake.
10. Report total to the charge nurse at the end of an eight (8)-hour shift.
11. Record intake and output, including eight (8)-hour totals, on intake-output record.

Test

Items Needed:
1. Food
2. Fluid containers
3. Worksheet
4. Intake-output chart
5. Equivalent chart
6. Patient

Task: Observe, measure and report food and fluid intake.

Standard:
1. All foods which should be measured as fluids must be identified.
2. All intake must be measured without errors.

Learning Activities

1. Read pages 359-374, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 346-352, Vol. II, 2nd Ed.) and/or pages 9-1 to 9-8, Being a Nursing Aide, 1st Ed. (pp. 177-183, 2nd Ed.).
2. Watch Trainex filmstrip "Intake and Output" #173.
3. Identify containers used to measure fluid volume.
4. Identify units of measure used to measure fluid volume.
5. Convert the volume of common food containers to cc. (Ex.:1/2 pt. of milk = 250 cc.)
6. Observe a demonstration by your instructor, including an introduction to the intake-output worksheet and the intake-output record used by your institution.
7. Practice measuring and recording fluid intake.
8. Have your instructor check your performance of this task.

Student Competency Sheet

Unit III: ASSISTING WITH NUTRITION AND ELIMINATION NEEDS OF PATIENTS

Module A: Intake

Task 2: DISTRIBUTE DRINKING WATER

Performance Checklist

1. Wash hands.
2. Note patients with special requirements, such as
   a. those who cannot have fluids.
   b. those who can have limited fluids.
   c. those who cannot have ice water.
3. Fill water pitchers in accordance with instructions.
4. Distribute water to appropriate patients.
5. Record amount of fluid given to patients on intake-output orders, if applicable.

Test

Items Needed:
1. Water pitchers
2. Drinking cups/glasses
3. Straw
4. Intake-output orders
5. Intake-output charts

Task: Distribute drinking water.

Standard:
1. Water must be distributed to appropriate patients.
2. Intake must be recorded where necessary.

Learning Activities

1. Read pages 123-124, Being a Nursing Aide, 2nd Ed.
2. Review the use of the intake and output worksheet and intake and output record.
3. Practice this task.
4. Have your instructor and/or fellow students evaluate your performance of this task.

Student Competency Sheet

Unit III: ASSISTING WITH NUTRITION AND ELIMINATION NEEDS OF PATIENTS

Module A: Intake

Task 3: ASSIST WITH SERVING OR FEEDING THE ADULT OR CHILD

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Provide for patient elimination.
4. Wash hands again.
5. Wash patient's hands and face.
6. Provide for oral hygiene.
7. Position patient.
8. Protect patient's clothes and bed linens.
9. See that proper tray is served to patient.
10. Sit while you feed patient.
11. Determine food preferences.
12. Serve food if acceptable to patient and rotate food offered.
13. Alternate food and liquid (1:3 or 1:4).
14. Remove food tray.
15. Provide for patient elimination.
16. Wash hands.
17. Wash patient's hands and face.
18. Provide for oral hygiene.
19. Position patient comfortably.
20. Record observations.

Test

Items Needed:

1. Patient, adult or child
2. Wash basin with warm water
3. Towel
4. Wash cloth
5. Soap
6. Drinking cup
7. Toothbrush
8. Toothpaste
9. Emesis basin
10. Diet list
11. Food tray (marked with patient's name and room number)

Task: Serve food to and/or feed an adult or child.

Standard:

1. Correct food tray is fed to patient.
2. Patient is fed in an unhurried, relaxed manner.
3. Solids and liquids are alternated.
4. Acceptable alternatives to maintain good nutrition may be offered.

Learning Activities

1. Read pages 343-357, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 335-341, Vol. I, 2nd Ed.).

2. Watch filmstrip, "Feeding the Patient" #373, by Trainex.

3. Watch the demonstration by the instructor.
4. Practice feeding an adult (fellow student).
5. Demonstrate feeding an adult patient (fellow student).
6. Practice feeding a child.
7. Demonstrate feeding a child.
8. Review intake and output charting.
9. Identify at least six (6) different types of patient's diets. Begin a listing of special diets for your reference.
10. List the four basic food groups and give examples of as many foods from these groups as you are able to. Have your instructor review your list.
11. Write daily menus for a patient:

    Day 1: Clear liquid
    Day 2: Full liquid
    Day 3: Soft diet (surgical and mechanical)
    Day 4: Regular (general or house) diet

Student Competency Sheet

Unit III: ASSISTING WITH NUTRITION AND ELIMINATION NEEDS OF PATIENTS

Module B: Elimination

Task 1: OBSERVE, MEASURE AND REPORT OUTPUT OF PATIENT

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Inform patient of intake-output procedure.
4. Collect output in a manner appropriate to patient's condition and sex.
5. Measure output in a graduated pitcher.
6. Observe output.
7. Record amount of output on worksheet.
8. Dispose of output.
9. Rinse receptacles in cold water; then wash.
10. Record total measurement on worksheet and report to charge nurse at the end of an eight (8)-hour shift.
11. Report and record pertinent observations.

Test

Items Needed:
1. Bedpan
2. Urinal
3. Graduated container
4. Intake-output record

Task: Observe, measure and report output of patient.

Standard:
1. Output must be collected in appropriate manner.
2. Output must be measured accurately and recorded.
3. Observations must be reported.

Learning Activities

1. Read pages 359-374, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 350-352, Vol. I, 2nd Ed.) and/or pages 9-1 to 9-8, Being a Nursing Aide, 1st Ed. (pp. 177-188, 2nd Ed.).

2. Identify equipment used to measure liquid output.

3. Watch a demonstration by your instructor.

4. Watch "Intake and Output" filmstrip #173 by Trainex.

5. Practice measuring and recording output of a patient.

6. Identify and list new vocabulary that might be used to describe urine, feces or vomitus.

7. List and define new terms in your vocabulary notebook.

Student Competency Sheet

Unit III: ASSISTING WITH NUTRITION AND ELIMINATION NEEDS OF PATIENTS

Module B: Elimination

Task 2: ASSIST PATIENT IN USING BEDSIDE COMMODE OR BATHROOM

Performance Checklist

1. Wash hands.
2. Identify patient and explain procedure.
3. Adjust bed to lowest position.
4. Provide for patient's privacy.
5. Position bedside commode parallel to bed.
6. Fold bed linens to the foot of the bed.
7. Assist patient to the dangling position.
8. Assist patient to standing position. Walk to bathroom or bedside commode.
9. Assist patient to turn and sit on commode chair. (NOTE: Never leave patient.)
10. Assist patient in cleansing genital and rectal area, as necessary.
11. Assist patient to return to bed.
12. Provide for patient's comfort. Provide for patient to wash hands.
13. Remove bedside commode, clean and return to storage.
14. Wash hands.
15. Note contents and record.

Test

Items Needed:	1. Patient	3. Bedside commode
	2. Bed	4. Toilet Tissue

Task: Assist the patient in using the bedside commode or bathroom.

Standard:
1. The patient must not be injured in the process.
2. The patient's condition will not be unduly aggravated.

Learning Activities

1. Read pages 403-404, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 304-305, Vol. II, 2nd Ed.).

2. Practice the task with fellow students in the learning laboratory.

3. Review new vocabulary used to describe urine and feces. Check definitions with your instructor.

4. Take the Self-Check Test and check your answers with the Answer Sheet.

5. Consult your instructor if you have questions about this task or the written evaluation.

SELF-CHECK TEST

Assist Patient in Using Bedside Commode or Bathroom
III-B-2

1. List two (2) important factors to be remembered when dangling the patient.

2. If this is the patient's first time to ambulate, what special precautions should you take?

3. What observations should you make?

4. Why is it important to provide privacy for your patient?

5. What should you remember when cleansing the patient's genital and rectal area?

6. Give an example of how you would record the procedure.

ANSWER SHEET

Assist Patient in Using Bedside Commode or Bathroom
III-B-2

1. a. Listen to patient's complaints of dizziness and weakness.
   b. Watch the patient's skin color for signs of paleness, sweating, coldness.

2. The patient may feel faint and weak. Always have another person to assist you. Do not leave the patient.

3. a. Skin color
   b. Note the strength of pulse beat
   c. Verbal complaints

4. The patient will be more comfortable and be able to complete the waste elimination process without any interruptions.

5. Always remember to wipe just once from the front of the genitalia to the anus, making sure to use a clean toilet wipe each time.

6. Need to include the following information: Patient, room and bed, time, how patient tolerated the task and characteristics of urine and stool (color, amount and form).

   Have your instructor read your example and offer suggestions and/or provide more opportunities to practice such charting skills.

Student Competency Sheet

Unit III: ASSISTING WITH NUTRITION AND ELIMINATION NEEDS OF PATIENTS

Module B: Elimination

Task 3: ASSIST PATIENT IN USING A BEDPAN

Performance Checklist

1. Wash hands.
2. Collect supplies.
3. Identify patient.
4. Screen patient for privacy.
5. Warm bedpan with warm water and dry.
6. Assist patient to flex knees or roll to side, if necessary.
7. Help patient onto bedpan:
    - a. Place bedpan under buttocks.
    - b. Return patient to supine position.
    - c. Adjust bedpan.
8. Raise head of bed, if appropriate.
9. Place toilet tissue near patient.
10. Place signal cord within easy reach, if appropriate.
11. Remove bedpan and cover.
12. Clean anal and genital area, if necessary.
13. Allow patient to wash hands.
14. Check appearance of excreta and report any abnormal findings.
15. Empty contents as instructed.
16. Clean and store supplies.
17. Wash hands.
18. Record observations.

Test

Items Needed:

1. Bed patient
2. Bedpan
3. Toilet tissue
4. Warm water
5. Bedpan cover
6. Specimen containers, if needed
7. Wash cloth
8. Towel
9. Soap

Task:

1. Assist the patient in using the bedpan.
2. Record observations of stool and urine.

Standard:

1. The patient must be positioned on bedpan so that:
    - a. patient's body is aligned and supported so that patient is not injured;
    - b. linens and clothing are not soiled.
2. Your recorded observations must closely match those of your instructor.

Learning Activities

1. Read pages 395-404, Nursing Skills for Allied Health Services, Vol. II, 1st ed. (pp. 240-241 and 298-300, Vol. I, 2nd ed.).
2. Read pages 7-25 to 7-29, Being a Nursing Aide, 1st ed. (pp.152-155, 2nd ed.).
3. Watch the demonstration by the instructor.
4. Practice the demonstration.
5. Describe normal and abnormal appearance of urine and stool.
6. Take the Self-Check Test and check answers.
7. Complete the performance checklist for this task.

SELF-CHECK TEST

Assist Patient in Using a Bedpan
III-B-3

1. Briefly describe three (3) abnormal stools in relation to color, form and amount.

2. Give an example of how you would record a patient's bowel movement on the patient's chart.

3. Briefly describe the color and reason for the normal color of stool in:

   a. newborns
   b. bottle fed babies
   c. breast fed babies
   d. adults

4. If the patient has changes in his bowel habits, what could this sign represent?

5. List two signs and symptoms of an infection in the urinary system.

6. Identify two situations when you would use a fracture pan.

7. Define the following words:

   a. frequency
   b. retention
   c. micturition
   d. incontinence

   Add these terms to your vocabulary notebook.

ANSWER SHEET

Assist Patient in Using a Bedpan
III-B-3

1. Clay colored - hard - small amount
   Black tarry - liquid - large amount
   Yellow - seedy - watery - moderate amount

2. Patient's name, room and bed, time, color, form and amount of stool should be included. Have your instructor check your terminology.

3. a. Newborns - black (meconium) old blood cells
   b. Bottle fed babies - yellow - no bile normally formed
   c. Breast fed babies - yellow - no bile normally formed
   c. Adults - brown - due to the formation of bile which adds coloring to the stool

4. A diseased intestine due to a growth or stricture of that part of the intestinal tract.

5. Burning on urination, frequency and urgency on urination, pain and discomfort around the kidney area. (Check other responses with your instructor.)

6. For patient with an injury to the pelvis or hip. For a patient that finds a standard bedpan to be uncomfortable. (Check other responses with your instructor.)

7. a. Frequency - to urinate often.
   b. Retention - failure to expel urine from the bladder.
   c. Micturition - the act by which urine is expelled.
   d. Incontinence - inability to retain feces or urine.

Name____________________________

Date____________________________

PERFORMANCE CHECK

Unit III, Module B, Task 3

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Wash hands.		
2. Collect supplies		
3. Identify patient.		
4. Screen patient for privacy.		
5. Warm bedpan with warm water and dry.		
6. Assist patient to flex knees or roll to side, if necessary.		
7. Help patient onto bedpan: a. Place bedpan under buttocks. b. Return patient to supine position. c. Adjust bedpan.		
8. Raise head of bed, if appropriate.		
9. Place toilet tissue near patient.		
10. Place signal cord within easy reach, if appropriate.		
11. Remove bedpan and cover.		
12. Clean anal and genital area, if necessary.		
13. Allow patient to wash hands.		
14. Check appearance of excreta and report any abnormal findings.		
15. Empty contents as instructed.		
16. Clean and store supplies.		
17. Wash hands.		
18. Record observations.		

Student Competency Sheet

Unit III: ASSISTING WITH NUTRITION AND ELIMINATION NEEDS OF PATIENTS

Module B: Elimination

Task 4: ASSIST PATIENT IN USING URINAL

Performance Checklist

1. Obtain necessary equipment.
2. Identify patient and explain procedure.
3. Provide for patient's privacy.
4. Wash hands.
5. Place urinal under top linen.
6. Allow patient to adjust urinal himself, if possible.
7. Raise head of bed.
8. Place call signal within easy reach of patient.
9. Remove urinal after patient has voided.
10. Measure amount, if I & O is ordered.
11. Note abnormalities, color and character.
12. Discard urine.
13. Rinse urinal, return to proper storage.
14. Provide for patient's comfort.
15. Allow patient to wash hands.
16. Wash your hands.
17. Record your observations.

Test

Items needed:
1. Male bed patient
2. Urinal
3. Cleansing items
4. Towel
5. Wash cloth
6. Soap
7. Basin of warm water

Task:
1. Assist the patient in using a urinal.
2. Measure amount, if I & O is ordered.
3. Record observations.

Standard:
1. The urinal must be administered in a manner to avoid embarrassment and soiling of the bed linens and patient's clothing.
2. Your recorded observations must match those of your instructor.

Learning Activities

1. Read pages 395-404, Nursing Skills for Allied Health Services, Vol. II, 1st ed. (pp. 242, 303-304. Vol. I, 2nd ed.).

2. Read pages 7-29, Being a Nursing Aide, 1st ed. (pp.151 and 155-156, 2nd ed.).

3. Watch the demonstration by the instructor.
4. Practice the procedure.
5. Have your instructor evaluate your performance.

Student Competency Sheet

UNIT III: ASSISTING WITH NUTRITION AND ELIMINATION NEEDS OF PATIENT

Module B: Elimination

Task 5: ASSIST WITH REMOVING OR REMOVE FECAL IMPACTION

Performance Checklist

1. Check physician's order.
2. Gather supplies and equipment.
3. Wash hands.
4. Identify patient.
5. Instruct patient regarding the procedure.
6. Screen patient for privacy.
7. Position patient in left Sims position, if appropriate.
8. Put on gloves and lubricant.
9. Examine patient for fecal impaction.
10. Break up and remove fecal impaction.
11. Remove remaining fecal material.
12. Provide for patient's comfort.
13. Observe fecal material and dispose of according to instructions.
14. Clean, store or dispose of supplies.
15. Wash hands.
16. Report and/or record procedure.

Test

Items Needed:
1. Patient
2. Bedpan
3. Bedpan cover
4. Gloves
5. Toilet tissue
6. Lubricant
7. Bed protector

Task: Remove a fecal impaction.

Standard:
1. The patient must be accorded privacy and comfort.
2. The lower colon must be free of fecal material that can be reached with the index finger.

Learning Activities

1. Read pages 436-443, Nursing Skills for Allied Health Services, Vol. II, 1st ed. (pp. 387-397, 401-406, 408-410, Vol. II, 2nd ed.).

2. Watch the filmstrip "Bowel Elimination" by Trainex.

3. Diagram the lower intestinal tract.

4. Identify the six (6) portions of the large intestine.

5. Watch a demonstration by your instructor.

6. After practice, perform a return demonstration for your instructor, using the laboratory mannequin.

UNIT IV

ASSISTING WITH TREATMENTS AND PROCEDURES

Terminal Objectives

Upon completion of the modules in this unit, you will:

- Measure and record patient's height and weight.
- Measure and record temperature, respiration and pulse (radial, temporal, femoral, carotid, pedal, and apical).
- Measure and record blood pressure.
- Time contractions and count fetal heart tones.
- Collect routine, "clean catch" and 24-hour urine specimens from adults and children.
- Collect urine specimen from an infant.
- Test urine for sugar and acetone.
- Collect sputum, stool, gastric and nose and throat specimens.
- Administer tepid, warm and sitz baths.
- Apply heat lamps, heating pads, local heat applications and heat packs.
- Apply local cold applications and ice bags.
- Turn a patient, using a turning frame or a Circ-O-Lectric bed.
- Set up a mist tent and vaporizer.
- Apply ace bandages, anti-embolic stockings and binders.
- Irrigate and dress wounds.
- Remove and replace burn dressings.
- Assist with or connect catheters and tubing to drainage.
- Measure and record contents of gastric and intestinal drainage bottles.
- Prepare and give a vaginal douche and a cleansing enema.
- Assist a patient with postural drainage.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module A. Measuring General Body Attributes

Task 1: MEASURE AND RECORD HEIGHT AND WEIGHT

Performance Checklist

1. Wash hands.
2. Identify patient and explain procedure.
3. Balance scale.
4. Assist patient to stand on scale.
5. Adjust scale and record weight.
6. Measure and record patient's height.
7. Assist patient off scale.
8. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's scale
3. Patient record

Task:
1. Measure and record the patient's height.
2. Measure and record the patient's weight.

Standard:
1. Height and weight must be measured without error.
2. Measurements must be recorded without error.

Learning Activities

1. Read page 380, Nursing Skills for Allied Health Services, Vol. I , 2nd Ed. and page 267, Being a Nursing Aide, 2nd Ed.

2. Watch a demonstration by your instructor for using a balance scale.

3. Watch a demonstration by your instructor for measurement of height and weight and recording such statistics.

4. Practice the task.

5. Role play a patient-care situation of measuring and recording a patient's height and weight. Practice as both a patient and a member of the nursing team. Have other students offer suggestions to improve your performance.

6. Perform a return demonstration for your instructor. Have your instructor check your charted statistics.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module A. Measuring General Body Attributes

Task 2: MEASURE AND RECORD TEMPERATURE

Performance Checklist

1. Identify patient and explain procedure.
2. Wash hands.
3. Select appropriate thermometer.
4. Shake thermometer down to 95° F. (35° C.) or below.
5. Wipe thermometer.
6. Take temperature by prescribed route of measurement.
   a. Oral method:
      (1) Have patient lie quietly in bed or sit in chair.
      (2) Place mercury tip of oral thermometer under patient's tongue.
      (3) Maintain thermometer in place for three (3) minutes and remove.
      (4) Read and record temperature.
      (5) Shake mercury down to 95°F. (35° C.) and replace to holder.
      (6) Wash hands.
      NOTE: Wait thirty (30) minutes before taking oral temperature of a patient who has had a hot or cold drink or has been smoking.
   b. Rectal method:
      (1) Position patient.
      (2) Lubricate thermometer.
      (3) Insert thermometer 1-1/2 inches into rectum.
      (4) Hold thermometer in place for three (3) minutes.
      (5) Remove thermometer.
      (6) Wipe thermometer clean.
      (7) Read and record temperature.
      (8) Clean thermometer, shake down and return to holder.
      (9) Wash hands.
   c. Axillary method:
      (1) Dry axilla.
      (2) Place thermometer under dry armpit.
      (3) Leave in place ten (10) minutes.
      (4) Remove thermometer and read temperature.
      (5) Clean thermometer, shake down and return to holder.
7. Take temperature by prescribed route using an electric thermometer. Follow closely all directions for the model being used.
8. Record all findings.

Test

Items Needed:
1. Patient
2. Oral thermometer
3. Rectal thermometer
4. Lubricant
5. Wipe tissue
6. Soap
7. Warm water
8. Electric thermometer and probe covers

Task:
1. Take the patient's oral temperature.
2. Take the patient's rectal temperature.
3. Take the patient's axillary temperature.

Standard:
1. The correct thermometer must be used.
2. The thermometer must remain in place the prescribed length of time.
3. The temperature must be read and reported to the nearest 2/10 of a degree Fahrenheit.
4. The temperature must be read and reported to the nearest 1/10 of a degree Centigrade.

Learning Activities

1. Read pages 523-531, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 258-269, Vol. I, 2nd Ed.) and/or pages 10-8 to 10-17, Being a Nursing Aide, 1st Ed. (pp. 231-249, 2nd Ed.).
2. Watch filmstrip "Temperature, Pulse and Respiration" by Trainex.
3. Attend a demonstration by your instructor. Observe the types of thermometers used.
4. Review information sheet with this task describing conversion of temperature from Fahrenheit to Centigrade.
5. Practice taking a classmate's oral and axillary temperature. Have your instructor check your performance.
6. Practice taking a rectal temperature, using the mannequin.
7. Practice recording a classmate's temperature on graphic paper supplied by your instructor. Do this for four days.
8. Measure and record the temperature of two fellow students.
9. Have your instructor evaluate your performance and make suggestions.

INFORMATION SHEET
IV-A-2

Conversion of Fahrenheit to Centigrade

(1°C = 1.8°F, 1°F = 0.54°C)

100°C = 212°F
95°C = 203°F
90°C = 194°F
85°C = 185°F
80°C = 176°F
75°C = 167°F
70°C = 158°F
65°C = 149°F
60°C = 140°F
55°C = 131°F
50°C = 122°F
45°C = 113°F

43°C = 109.4°F
42°C = 107.6°F
41.5°C = 106.7°F
41°C = 105.8°F
40.5°C = 104.9°F
40°C = 104°F
39.5°C = 103.1°F
39°C = 102.2°F
38.5°C = 101.3°F
38°C = 100.4°F
37.5°C = 99.5°F
*37°C = 98.6°F

36.5°C = 97.7°F
36°C = 96.8°F
35.5°C = 95.9°F
35°C = 95°F
32°C = 89.6°F
30°C = 86°F
25°C = 77°F
20°C = 68°F
15°C = 59°F
10°C = 50°F
5°C = 41°F
0°C = 32°F

*Standard for Normal Body Temperature

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Moduel A: Measuring General Body Attributes

Task 3: MEASURE AND RECORD RESPIRATION

Performance Checklist

1. Assemble necessary equipment and supplies
   a. Watch with second hand
   b. Note pad
   c. Pen
2. Identify patient.
3. Place patient in a position where respiration can be easily observed or cross arm across patient's chest where respiration can be easily felt (as if taking pulse).
4. Observe rhythm, rate and depth of respiration for a full minute (without patient being aware of procedure), or count for thirty (30) seconds and multiply the rate by two (2).
5. Record rate of respiration per minute.

Test

Items Needed:
1. Patient
2. Watch with second hand
3. Note pad
4. Pen or pencil

Task: Measure and record the respiratory rate of a patient

Standard:
1. The rate must be ±2 of that found by instructor.
2. The rhythm and depth must agree with the instructor's findings.

Learning Activities

1. Read pages 534-535, Nursing Skills for Allied Health Services, Vol. II, 1st ed. (pp. 269-272, 274-276, Vol. I, 2nd ed.) and/or pages 10-18 to 10-20, Being a Nursing Aide, 1st ed. (pp. 253-255, 2nd ed.).

2. View filmstrip "Normal Breath Sounds" #425 by Trainex.

3. Identify the reason for the rise and fall of the chest wall; discuss with your instructor.

4. In small groups, observe your instructor measuring and recording respiration.

5. Practice the task.

6. In small groups, identify various factors that effect the rate, rhythm and depth of respirations.

7. Compile a list of these factors and have your instructor check your accuracy. Retain the list for reference.

8. Combine this task with measuring and recording temperature. (You may find it easier to count respirations without a fellow student being aware of the procedure if you combine it with another task.)
9. Have your instructor evaluate your performance of this task.
10. Identify new terms used to describe the rate, rhythm and depth of respirations.
11. Add these terms to your vocabulary notebook. Have your instructor check your definitions.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module A: Measuring General Body Attributes

Task 4: MEASURE AND RECORD PULSE (RADIAL, TEMPORAL, FEMORAL, CAROTID, PEDAL)

Performance Checklist

1. Wash hands.
2. Assemble equipment and supplies:
   a. Watch with second hand
   b. Note pad
   c. Pen
3. Identify patient.
4. Explain procedure.
5. Place three (3) middle fingertips over appropriate artery.
6. Count pulsations for specified period (sixty (60) seconds if inexperienced or if patient has slow, irregular pulse or heart disease, thirty (30) seconds X two (2) when student becomes comfortable with procedure).
7. Observe the force and rhythm of the beats.
8. Record pulse rate and report any unusual characteristics.

Test

Items Needed:
1. Patient
2. Watch with a second hand
3. Note pad
4. Pen

Task:
1. Measure and record the radial pulse rate.
2. Measure and record the temporal pulse rate.
3. Measure and record the femoral pulse rate.
4. Measure and record the carotid pulse rate.
5. Measure and record the pedal pulse rate.

Standard:
1. Your count must be accurate within ± 2.
2. The force and rhythm reported must agree with instructor's findings.
3. All checksheet items must be rated acceptable.

Learning Activities

1. Read pages 531-533, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 249-251, Vol. I, 2nd Ed.) and/or pages 10-17 to 10-18, Being a Nursing Aide, 1st Ed. (pp. 249-251, 2nd Ed.).

2. Watch filmstrip, "Temperature, Pulse and Respiration", by Trainex.

3. Attend lecture by your instructor on the Anatomy of the Circulatory System.

4. Watch demonstration by your instructor of measurement and recording the pulse.

5. Watch a demonstration by your instructor combining the measurement of temperature, pulse and respiration.

6. Locate the five (5) points on your body where the pulse can be measured.

7. Practice this task, alone and combined with measurement of temperature and respiration.

8. List eight (8) factors that influence a pulse rate. Discuss your list with your instructor.

9. Complete the performance checksheet for this task.

10. Identify new terms to describe the rate, force and rhythm of the pulse.

11. Enter these terms in your vocabulary notebook and have your instructor check your definitions for accuracy.

12. View, again, Trainex filmstrip, "Temperature, Pulse and Respiration" - PC#371.

Name____________________________

Date____________________________

Unit IV, Module A, Task 4

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Wash hands		
2. Assemble equipment and supplies: a. Watch with second hand b. Note pad c. Pen		
3. Identify patient.		
4. Explain procedure.		
5. Place three (3) middle fingertips over appropriate artery.		
6. Count pulsations for specified period (60 seconds if unexperienced or if patient has slow, irregular pulse or heart disease, 30 seconds X 2 when student becomes comfortable with procedure).		
7. Observe the force and rhythm of the beats.		
8. Record pulse rate and report any unusual characteristics.		

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module A: Measuring General Body Attributes

Task 5: MEASURE AND RECORD PULSE (APICAL)

Performance Checklist

1. Wash hands.
2. Assemble equipment and supplies:
    a. Stethoscope
    b. Watch with second hand
    c. Note pad
    d. Pen
    e. Antiseptic gauze
3. Identify patient.
4. Explain procedure.
5. Position and drape patient.
6. Place stethoscope in correct position (warming diaphragm in your hand first).
7. Count the heart beats for a full minute, noting rate, rhythm and strength of beat.
8. Observe the force and rhythm of the beats.
9. Remove stethoscope, wiping ear pieces and diaphragm with antiseptic gauze.
10. Record pulse rate as designated and report any unusual characteristics.
11. Store equipment and supplies.

Test

Items Needed:
1. Patient
2. Stethoscope
3. Watch with a second hand
4. Note pad
5. Pen

Task: Measure and record the apical pulse rate.

Standard:
1. Your count must be accurate to within ±2.
2. The force and rhythm reported must agree with instructor's findings.
3. All checksheet items must be rated acceptable.

Learning Activities

1. Read pages 533-534, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 272-274, Vol. I, 2nd Ed.) and/or pages 252-253, Being a Nursing Aide, 2nd Ed.

2. Watch filmstrips, "The Heart Anatomy I and II", by Trainex.

3. List new terms from the filmstrip in your vocabulary notebook. Have your instructor check your definitions.

4. Listen to available cassettes, such as "Pulse and Blood Pressure Variations."

5. Observe your instructor's demonstration of the task.
6. Practice the task repeatedly with fellow students.
7. Listen to available cassettes again, if you feel it would be helpful.
8. List questions you have regarding the counting or evaluation of the apical pulse. Discuss these with your instructor.
9. Complete the performance checksheet for this task.

Name________________________
Date________________________

PERFORMANCE CHECK

Unit IV, Module A, Task 5

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Wash hands.		
2. Assemble equipment and supplies: stethoscope, watch with second hand, note pad, pen or pencil and antiseptic gauze.		
3. Identify patient.		
4. Explain procedure.		
5. Position and drape patient.		
6. Place stethoscope in correct position (warming diaphragm in your hand first).		
7. Count the heart beats for a full minute, noting rate, rhythm and strength of beat.		
8. Observe the force and rhythm of the beats.		
9. Remove stethoscope, wiping ear pieces and diaphragm with antiseptic gauze.		
10. Record pulse rate as designated and report any unusual characteristics.		
11. Store equipment and supplies.		

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module A: Measuring General Body Attributes

Task 6: MEASURE AND RECORD BLOOD PRESSURE

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Assemble supplies and equipment, making sure cuff is of proper size.
5. Clean ear pieces and diaphragm of stethoscope with antiseptic.
6. Position equipment and patient.
7. Wrap blood pressure cuff around patient's arm with edge of cuff about two (2) inches above the elbow, securing firmly. Sphygmomanometer should be level with patient's chest and at assistant's eye level.
8. Attach tubes to blood pressure cuff.
9. Feel for pulsations of brachial artery with fingertips positioned over inner aspect of the antecubital area; then place diaphragm of stethoscope over pulsations.
10. Close valve on air bulb and pump air bulb with hand until the column of mercury or needle on gauge reaches 180mm; if beats are heard, release pressure; wait 15 seconds and pump approximately 20mm higher or until no beats are heard.
11. Open valve on the air bulb, releasing the pressure slowly.
12. Note the systolic and diastolic reading.
13. Check accuracy by repeating process if necessary, after waiting at least fifteen (15) seconds.
14. Record blood pressure.
15. Remove, clean and store equipment.

Test

Items Needed:
1. Patient
2. Stethoscope
3. Sphygmomanometer
4. Note pad
5. Pen or pencil

Task:
1. Measure blood pressure.
2. Record blood pressure.

Standard:
1. Both the systolic and diastolic readings must be within ±4 points of that found by the instructor.
2. All checksheet items must be rated acceptable.

Learning Activities

1. Read pages 10-21 to 10-26, *Being a Nursing Assistant*, 1st Ed. (pp. 255-262, 2nd Ed.) and/or pages 535-539, *Nursing Skills for Allied Health Services*, Vol II, 1st Ed. (pp. 276-281, Vol. I, 2nd Ed.).

2. Watch filmstrip, "Blood Pressure" PC367, by Trainex.

3. Observe a demonstration by your instructor.

4. Listen to available cassettes, such as "Variations In Pulse and Blood Pressure."

5. Practice inflating the cuff attached to the arm of the Chase doll to 180mm. Deflate cuff.

6. Practice finding the brachial pulse on the lateral side of the elbow joint.

7. Do the Post-Test in Nursing Skills for Allied Health Services, Vol. II, 1st Ed., pages 540-541 (pp. 291-292, Vol. I, 2nd Ed.). Check your answers with the Answer Sheet.

8. Practice this task.

9. Complete the performance checksheet.

Name________________________
Date________________________

PERFORMANCE CHECK

Unit IV, Module A, Task 6

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Wash hands.		
2. Identify patient.		
3. Explain procedure.		
4. Assemble supplies and equipment, making sure cuff is of proper size.		
5. Clean ear pieces and diaphragm of stethoscope with antiseptic.		
6. Position equipment and patient.		
7. Wrap blood pressure cuff around patient's arm with edge of cuff about two (2) inches above the elbow, securing firmly. Sphygmomanometer should be level with patient's chest and at assistant's eye level.		
8. Attach tubes to blood pressure cuff.		
9. Feel for pulsations of brachial artery with fingertips positioned over inner aspect of the antecubital area; then place diaphragm of stethoscope over pulsations.		
10. Close valve on air bulb and pump air bulb with hand until the column of mercury or needle on gauge reaches 180mm; if beats are heard, release pressure; wait 15 seconds and pump approximately 20mm higher or until no beats are heard.		
11. Open valve on the air bulb, releasing the pressure slowly.		
12. Note the systolic and diastolic reading.		
13. Check accuracy by repeating process if necessary, after waiting at least 15 seconds.		
14. Record blood pressure.		
15. Remove, clean and store equipment.		

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module A: Measuring General Body Attributes

Task 7: TIME CONTRACTIONS

Performance Checklist

1. Wash hands.
2. Identify patient and explain procedure.
3. Place hands on patient's abdomen at the level of the fundus.
4. To determine the duration of uterine contraction:
   a. Note time at the beginning of uterine contraction.
   b. Note time when uterine muscle completely relaxes.
   c. Interval of time during contraction is duration of contraction.
5. To determine frequency of uterine contraction:
   a. Note time when uterine muscle completely relaxes after contraction.
   b. Note time when next uterine contraction starts.
   c. Interval of time from end of one contraction to the beginning of another is the frequency of contractions.
6. Continue process and keep record of duration and frequency.
7. Report and record, if applicable.
8. Report and record pertinent observations.

Test

Items Needed: 1. Patient in labor 2. Watch

Task: Time the patient's contractions.

Standard:
1. Timing must include the frequency and duration of the contractions.
2. Timing must be without error.
3. Timing must not cause any undue discomfort for the patient.

Learning Activities

1. Read:
   a. Pages 85-86, "Timing Obstetrical Contractions," Maternal Child Health Nursing and/or
   b. Pages 267-268, "Uterine Contractions," Maternity Nursing, and/or
   c. Pages 104-105, "Contractions," Basic Maternity Nursing.

2. Review anatomy of female reproductive system and mechanism of labor.

3. Observe instructor timing contractions of patient in labor.

4. Complete workbook: "Labor", p. 101-103, Workbook in Bedside Maternity Nursing, Bleick.

5. View Filmstrips:
"Complications of Labor" - Trainex
"Delivery" - Trainex #409
"Emergency Childbirth" - Trainex #351

6. Practice performance in agency setting with your instructor's supervision.

7. Have your instructor supervise and evaluate your performance of this task until stated standards are consistently met.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module A: Measuring General Body Attributes

Task 8: COUNT AND REPORT FETAL HEART TONES

Performance Checklist

1. Identify patient and explain procedure.
2. Position patient.
3. Put on fetoscope.
4. Locate fetal heart tone.
5. Listen and count fetal heart tones for 1 minute.
6. Report and record.
7. If ultrasonic transducer is used, follow this procedure:
   a. Put on heat set and insert plug into monitor.
   b. Connect transducer cable to fetal heart rate (FHR) input jack.
   c. Apply conductive gel to the transducer crystal.
   d. Apply and adjust elastic belt.
   e. Adjust transducer on patient's abdomen.
   f. Adjust volume on head set.
   g. Check monitor for best placement of transducer.
8. Provide for patient's comfort.
9. Record procedure.

Test

Items Needed:
1. Patient in labor
2. Fetoscope
3. Ultrasonic transducer
4. Conductive gel
5. Pen
6. Proper form to record tones

Task:
1. Count the fetal heart tones.
2. Record the fetal heart tones.

Standard: The count must be accurate to within ±5.

Learning Activities

1. Read:
   a. Page 58 "Fetal Heart Tone (FHT) and Funic Souffle," Basic Maternity Nursing, and/or
   b. Pages 86-92, "Fetal Heart Rate Evaluation," Maternal Child Health Nursing, and/or
   c. Pages 157-159, "Fetal Heart Sounds," Maternity Nursing.
2. Attend lecture and demonstration of maneuver to determine position of fetus and placement of fetoscope.

3. View filmstrip:
"Nursing Care of the Newborn, Circulation of the Fetus and Transitional Circulation of the Newborn" - Trainex

4. Practice performance in agency setting with instructor's supervision.

5. Practice using agency charting forms to record fetal heart tones.

6. Discuss: Normal fetal heart tones vs. abnormal fetal heart tones. Include distinguishing characteristics and descriptive terms.

7. Identify new terms used in the research and/or reporting and recording of this task. Enter these terms in your vocabulary notebook.

8. Have your instructor supervise your performance of this task. Have your instructor evaluate your performance until all standards listed are met.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module B: Collecting Specimens

Task 1: COLLECT A ROUTINE URINE SPECIMEN

Performance Checklist

1. Collect necessary equipment.
2. Wash hands.
3. Identify patient.
4. Inform patient that a specimen is needed.
5. Provide privacy.
6. Have patient urinate into bedpan or urinal.
7. Offer patient equipment for washing hands.
8. Take bedpan to bathroom.
9. If patient is on output, measure output.
10. Pour about 1/2 C. or 3-4 ounces of urine into specimen bottle.
11. Put cap on bottle.
12. Label bottle immediately.
13. Pour rest of urine in toilet and flush.
14. Clean the bedpan or urinal and put away.
15. Wash hands.
16. Report that urine specimen has been obtained.
17. Follow instructions for sending specimen to laboratory.

Test

Items Needed:
1. Patient
2. Bedpan or urinal
3. Specimen bottle and label
4. Required laboratory requisitions

Task: Collect a urine specimen from a patient.

Standard:
1. Three to four ounces of urine must be in the specimen bottle.
2. The container must be labeled with the date, the patient's name and room number.

Learning Activities

1. Read pages 404-407, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 305-307, Vol. I, 2nd Ed.). Review the diagrams and procedures contained in this reading. Refer to vocabulary on Information Sheet for this task.
2. Review the "Key Ideas: Asepsis in Specimen Collection" on page 9-12, Being a Nursing Aide, 1st Ed. (p. 191, 2nd Ed.). Discuss this key idea with a classmate.
3. Attend the demonstration given by your instructor concerning specimen collection. Take notes and ask questions during this time.
4. Watch filmstrip, "Collecting Urine Specimen", provided by Trainex, #339.
5. In a classroom practice situation, to be provided by your instructor, collect a urine specimen using proper techniques. Use the Self- Check List for this task and ask your instructor to observe your technique.

INFORMATION SHEET
IV-B-1

Urinary System and Specimen Collection

1. fracture pan - a specific type of shallow bedpan used by bed patients who have difficulty raising their hips in order to use the regular bedpan.
2. frequency - the condition of having to urinate often.
3. incontinence - the inability to retain feces or urine; lack of voluntary control over the sphincters.
4. preservative - an agent having the power to keep a substance from decaying or spoiling.
5. rectum - the distal portion of the large intestine located between the sigmoid and the anal canal.
6. retention - failure to expel the urine from the bladder.
7. urgency - the immediate need to urinate.
8. vagina - the mucomembranous tube that joins the passageway between the uterus and the external opening (vaginal:related to the vagina).
9. vulva - the external female genitalia.
10. bedpan - is made of metal or plastic. Each patient has an individual bedpan stored in the bedside stand during his hospital stay.
11. bedpan cover - is made of cloth or paper. It is used to mask the unpleasant sight and odor of the pan's contents after it has been used.
12. disposable strainer - a throwaway, funnel shaped item, used to strain urine to filter out any possible kidney stones or foreign matter.
13. stool cup - a disposable specimen container used for collection of fecal material to be sent for laboratory studies.
14. urine specimen container - a plastic disposable, or glass bottle container used for the collection of routine urine specimens.

SELF-CHECK LIST
IV-B-1

Collect a Routine Urine Specimen

Do you have:

a. A patient?
b. A bedpan or urinal?
c. A specimen container?
d. Proper labels and lab request sheets?

Have you:

a. Washed your hands?
b. Informed your patient of the procedure?
c. Collected specimen in bedpan or urinal?
d. Transferred specimen (3-4 ozs.) to specimen container?
e. Washed your hands?
f. Properly labeled the specimen and attached lab request sheet?

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module B: Collecting Specimens

Task 2: COLLECT A CLEAN CATCH URINE SPECIMEN

Performance Checklist

1. Wash hands.
2. Gather sterile equipment.
3. Identify patient.
4. Screen patient.
5. Explain procedure.
6. Position patient according to instructions.
7. Put waterproof sheet under genital area.
8. Position bedpan or urinal.
9. Wash your hands.
10. Wash genital area with appropriate solution.
11. Have patient void into bedpan or urinal (do not use first one (1) or two (2) ounces for specimen).
12. Interrupt urine flow.
13. Collect midstream specimen.
14. Rinse patient if appropriate.
15. Wash hands.
16. Report that specimen has been collected.
17. Send specimen to laboratory.
18. Clean and store equipment.

Test

Itens Needed:

1. Patient
2. Water
3. Soap solution
4. Gauze pads
5. Wash basin
6. Disposable midstream specimen set
7. Bedpan or urinal
8. Waterproof sheet
9. Specimen bottle

Task: Collect a clean catch urine specimen from a patient.

Standard:

1. The genitalia must be cleansed.
2. A midstream urine specimen must be obtained in a sterile container without contaminating specimen bottle.
3. The specimen must be labeled with the date, the patient's name and room number.

Learning Activities

1. Read pages 408-409, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 307-309, Vol. I, 2nd Ed.).

2. View Trainex filmstrip, "Collecting Urine Specimens." After viewing, collect all the equipment needed for this procedure.

3. Ask your instructor to explain or demonstrate any part of the procedure that you do not understand.

4. In a simulated situation in the classroom laboratory (using a mannequin), practice the procedure for collecting a clean catch specimen.

5. Perform a return demonstration for your instructor. Have your instructor evaluate your performance.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module B: Collecting Specimens

Task 3: COLLECT A 24-HOUR URINE SPECIMEN

Performance Checklist

1. Collect necessary equipment and prepare equipment according to hospital laboratory standards.
2. Label bottle.
3. Wash hands.
4. Identify patient.
5. Inform patient that all urine voided in a 24-hour period will be saved.
6. Dispose of first specimen (unless otherwise instructed).
7. Collect all urine voided for the specified 24-hour period.
8. After collection is complete, take immediately to laboratory.
9. Clean equipment.
10. Wash hands.
11. Report that specimen has been collected.

Test

Items Needed:

1. Patient
2. Bedpan or urinal
3. Large bottle
4. Funnel
5. Time schedule for specimen collection

Task: Collect a 24-hour urine specimen.

Standard:

1. The first specimen must be disposed.
2. All urine must be collected for 24 hours.
3. Specimen containers must be labeled with the date, the patient's name and room number.

Learning Activities

1. Read pages 409-411, *Nursing Skills for Allied Health Services*, Vol. II, 1st Ed. (pp. 309-311, Vol. I, 2nd Ed.).

2. Review labeling accuracy Self-Check List included with this task.

3. Attend lecture/demonstration by your instructor on collecting a 24-hour urine specimen.

4. After assembling the necessary equipment in the skill laboratory, practice the simulated procedure for this task. Ask your instructor to assist you as needed.

SELF-CHECK LIST
IV-B-3

Labeling Accuracy

Did you?

1. Check identification bracelet.
2. Print clearly so the label can be easily read.
3. Put label on specimen immediately after specimen container has been collected.
4. Check identification bracelet. Copy the patient's name from it.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module B: Collecting Specimens

Task 4: COLLECT URINE SPECIMEN (INFANT)

Performance Checklist

1. Wash hands.
2. Assemble equipment and supplies.
3. Identify patient.
4. Collect urine specimen.
    a. Cleanse genitalia.
    b. Attach and secure urine receptacle.
    c. After obtaining specimen:
        (1) Remove receptacle.
        (2) Cleanse and dry genitalia.
        (3) Diaper infant.
5. Label specimen.
6. Send to lab.
7. Record procedure.

Test

Items Needed:
1. Physician's order
2. Infant
3. Urine receptacle
4. Specimen container
5. Label
6. Laboratory requisition
7. Cleansing and drying materials
8. Powder or oil
9. Diaper

Task: Collect a urine specimen.

Standard:
1. At least one (1) cc of urine must be collected.
2. Specimen must be properly labeled for laboratory identification and testing.

Learning Activities

1. Read pages 207-208, Being a Nursing Aide, 1st Ed.
2. Watch a demonstration by your instructor.
3. Practice this procedure in the nursing laboratory using a doll or mannequin.
4. Demonstrate this task for a group of classmates. Have fellow students role play parents who might need an explanation of such a procedure.
5. Have your instructor evaluate your performance of this task in the laboratory.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module B: Collecting Specimens

Task 5: TEST URINE FOR SUGAR AND ACETONE

Performance Checklist

1. Check physician's orders.
2. Assemble supplies.
3. Wash hands.
4. Carry specimen to designated testing area.
5. To test urine for sugar:
   a. Test-tube method. CAUTION: Hold the test tube near the top to avoid burning fingers.
      (1) Drop five (5) drops of urine into test tube.
      (2) Rinse dropper.
      (3) Drop ten (10) drops of water into test tube.
      (4) Gently rotate test tube to mix urine and water.
      (5) Add one (1) clinitest tablet to mixture. CAUTION: Do not rotate test after adding clinitest tablet.
      (6) Observe reaction.
      (7) Compare color with color chart.
      (8) Record observations.
   b. Tes-tape method.
      (1) Remove 1-1/2 inches of tes-tape from dispenser.
      (2) Dip one end into urine specimen.
      (3) Remove from urine and wait one (1) minute.
      (4) Compare tape with color chart.
      (5) Record observations.
6. Test urine for acetone:
   a. Acetest - tablet method.
      (1) Place one (1) acetest tablet on clean paper towel.
      (2) Place one (1) drop of urine on tablet.
      (3) Observe for thirty (30) seconds.
      (4) Compare color with color chart.
      (5) Record observations.
   b. Ketostix method:
      (1) Obtain ketostix.
      (2) Dip designated end into urine.
      (3) Remove excess urine from test strip.
      (4) Wait fifteen (15) seconds.
      (5) Compare ketostix with color chart.
      (6) Record observations.
7. Test urine sugar/acetone method.
   a. Keto-diastix method.
      (1) Obtain keto-diastix.
      (2) Place designated end in urine for two (2) seconds.
      (3) Remove excess urine.
      (4) Compare ketone reagent area of test strip with color chart.
      (5) Wait thirty (30) seconds.
      (6) Compare glucose reagent area of strip to color chart.
      (7) Record observations.

Test

Items Needed:

1. Urine specimen
2. Physician's orders
3. Test tube
4. Dropper
5. Water
6. Clinitest tablet
7. Color chart
8. Tes-tape
9. Acetest tablet
10. Paper towel
11. Ketostix
12. Keto-diastix

Task: Test the urine for sugar and/or acetone using the following methods:

1. Test-tube method
2. Tes-tape method
3. Acetest-tablet method
4. Ketostix method
5. Keto-diastix method

Standard: All results must be determined and recorded without error.

Learning Activities

1. Read pages 202-207, Being a Nursing Aide, 2nd Ed. and/or pages 412-418, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 313-318, Vol. I, 2nd Ed.).

2. Watch the Trainex filmstrip, "Testing Urine for Glucose and Ketones."

3. Attend demonstration by the instructor on this procedure.

4. After collecting all the equipment you need - and a voided urine specimen - practice the procedure. Check yourself using the Performance Checklist for this task.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module B: Collecting Specimens

Task 6: COLLECT SPUTUM SPECIMEN

Performance Checklist

1. Collect necessary supplies.
2. Wash hands.
3. Identify patient.
4. Explain procedure.
5. Label container.
6. Have patient rinse out mouth.
7. Instruct patient to deep cough and expectorate sputum rather than saliva in container (an early morning specimen is usually required).
8. Wash hands.
9. Send specimen to proper place.
10. Report that specimen was obtained and the character of the sputum.

Test

Items Needed:
1. Patient
2. Sterile sputum containers
3. Labels

Task: Collect a sputum specimen.

Standard:
1. The specimen must be sputum.
2. The containers must be labeled with the date, the patient's name and room number.

Learning Activities

1. Read pages 474-476, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 547-548, Vol. II, 2nd Ed.) and/or pages 9-17 to 9-19, Being a Nursing Aide, 1st Ed. (pp. 197-198, 2nd Ed.).

2. In your notebook write:

   a. Key points of the procedure.
   b. The reasons for collecting sputum specimens.

3. Role play a patient-care situation of a patient who needs an explanation for this procedure. Participate as both a patient and a member of the nursing team.

4. Practice this task using the laboratory mannequin. Include a patient explanation.

5. Have your instructor evaluate your performance of this task and make suggestions.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module B: Collecting Specimens

Task 7: COLLECT STOOL SPECIMENS

Performance Checklist

1. Check physician's orders.
2. Wash hands.
3. Assemble equipment and supplies.
4. Identify patient and explain procedure.
5. Prepare bedpan or bedside commode for collection of stool.
6. Provide for patient's privacy.
7. Take bedpan or bedside commode with stool to utility room or appropriate area.
8. With tongue blades, remove feces and place into specimen container.
9. Seal and label specimen container.
10. Provide for patient's comfort.
11. Send properly labeled specimen to laboratory, immediately.
12. Wash hands.
13. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Laboratory requisition
4. Bedpan or bedside commode
5. Tongue blades
6. Cleaning materials
7. Specimen container
8. Label

Task:
1. Collect a stool specimen.
2. Prepare the stool specimen for laboratory analysis.

Standard:
1. The specimen must be of sufficient quantity for laboratory analysis.
2. The specimen must be placed in an appropriate container.
3. The specimen container must be correctly labeled.
4. The specimen must be accompanied by a laboratory slip identifying:
   a. the patient.
   b. test to be performed.

Learning Activities

1. Read pages 9-19 and 9-20, Being a Nursing Aide, 1st Ed. (pp. 199-200, 2nd Ed.) and/or pages 449-450, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 406-407, Vol. I, 2nd Ed.).
2. Ask your instructor to explain or demonstrate any part of the procedure you do not understand.
3. Practice the simulation of this task in the laboratory.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module B: Collecting Specimens

Task 8: COLLECT GASTRIC SPECIMENS

Performance Checklist

1. Check physician's orders.
2. Check equipment, supplies and requisition form.
3. Wash hands.
4. Identify patient and explain procedure.
5. Pour vomitus or aspirated gastric contents into specimen container.
   a. Place cover on specimen container after pouring contents.
   b. Wash and dry outer surface of container if soiled when pouring contents.
   c. Check label and apply to container.
6. Send labeled specimen, with requisition, to laboratory.
7. Provide for patient's comfort and safety.
8. Clean equipment and return to storage.
9. Wash hands.
10. Record appropriately.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Laboratory requisition
4. Specimen container
5. Container cover
6. Label

Task:
1. Collect a gastric specimen.
2. Prepare the specimen for laboratory analysis.

Standard:
1. The specimen must be of sufficient quantity for laboratory analysis.
2. The specimen must be placed in an appropriate container.
3. The specimen container must be correctly labeled.
4. The specimen must be accompanied by a laboratory slip identifying:
   a. the patient.
   b. tests to be performed.

Learning Activities

1. Read pages 9-23 and 9-24, Being a Nursing Aide, 1st Ed. (pp. 286-289, 2nd Ed.) and/or pages 478-479, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 545-565, Vol. II, 2nd Ed.).
2. Attend lectures and demonstrations by the instructor for this task.
3. Review the vocabulary list on Information Sheet included with this task. Enter new terms in your vocabulary notebook.
4. Identify patient-care situations when this procedure might be ordered. Discu your list with your instructor.
5. Have your instructor supervise and evaluate your performance of this task in the hospital setting.

INFORMATION SHEET

IV-B-8

Vocabulary

The patient with gastrointestinal tubes:

1. aspiration - the act of drawing in or out of a cavity of the body by suction; withdrawing of fluid from a body cavity by suction with an instrument called an aspirator.
2. distention - the state of being stretched out or bloated, as the abdominal cavity may be with gas or fluid.
3. emesis - vomiting.
4. Gomoco Thermatic Pump - a special electric suction machine commonly used with various gastrointestinal tubes.
5. lavage - the washing out of a cavity; gastric lavage is the washing out of the stomach contents, which is done in emergency cases such as that of a child who has swallowed a poisonous fluid.
6. Levin tube - a long plastic or rubber single-lumen tube that is inserted through the nose or mouth to the stomach and used to drain off stomach fluids and to keep the stomach decompressed.
7. Wangensteen suction - an early type of water displacement suction apparatus used with various gastrointestinal tubes for drainage.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module B: Collecting Specimens

Task 9: COLLECT NOSE OR THROAT SPECIMENS FOR CULTURE

Performance Checklist

1. Check physician's orders.
2. Assemble supplies.
3. Wash hands.
4. Identify patient and explain procedure.
5. Position patient.
6. To obtain nasal specimen:
   a. Remove sterile applicator from culture tube.
   b. Swab once inside upper portion of one nostril.
   c. Remove swab and seal in culture tube.
   d. Repeat procedure for second nostril.
7. To obtain throat specimen:
   a. Depress tongue with tongue blade.
   b. Remove sterile applicator from culture tube.
   c. Swab downward over one tonsillar area.
   d. Remove applicator and seal in culture tube.
   e. Repeat procedure for second tonsillar area.
8. Provide for patient's comfort.
9. Label culture tubes and attach requisition.
10. Send specimen to laboratory immediately.
11. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Laboratory requisition
4. Culture tubes (4)
5. Sterile swabs (4)
6. Tongue blade
7 Labels

Task:
1. Collect a nose specimen for culture.
2. Collect a throat specimen for culture.
3. Prepare the specimens for laboratory analysis.

Standard:
1. The specimens must be obtained without contamination from other scources.
2. The specimen containers must be properly labeled.
3. The specimens must be accompanied by a laboratory requisition slip(s) identifying:
   a. the patient
   b. test to be performed.
4. The specimens must be sent to the laboratory immediately.

Learning Activities

1. Read pages 325-327 and 340-341, Nursing Skills For Allied Health Services, 2nd Ed. or another reference with illustrations of the pre-packaged equipment used at your teaching hospital.

2. Attend a laboratory demonstration and discussion illustrating the various pre-packaged kits used to obtain these specimens.

3. List the special precautions for handling and delivering a specimen for culture. Identify why each precaution is vital to providing an accurate identification of organisms.

4. Have your instructor check your list of precautions. Discuss the lists in small groups.

5. Practice the procedure in simulated situations in the laboratory.

6. Have your instructor supervise you and evaluate your performance in the clinical setting.

7. Repeat the task, with supervision, until all standards are rated "adequate" by your instructor.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 1: ADMINISTER TEPID BATHS

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Wash hands.
5. Prepare bath water.
6. Check TPR.
7. Place one bath blanket under the patient, another over the patient.
8. Remove patient's clothing.
9. Bathe arms.
10. Wet wash cloths in solution and place on patient's groin and abdomen. Change as needed.
11. Bathe legs.
12. Remove wash cloths from groin and abdomen.
13. Bathe patient's back and buttocks.
14. Check patient's temperature and determine need to repeat bath.*
15. Tidy area.
16. Record procedure.

* Alcohol may be added to bath water.

Test

Items Needed:

1. Patient with elevated temperature
2. Bath water
3. Two blankets
4. Wash cloths
5. Towels
6. Alcohol

Task: Administer a tepid bath.

Standard:

1. TPR must be taken immediately before the bath is administered and checked every fifteen (15) minutes.
2. Bath must be administered without discomfort or injury to the patient.

Learning Activities

1. Read pages 182-183, Nursing Skills for Allied Health Services, Vol. I, 1st Ed. (pp. 573-596, Vol. II, 2nd Ed.), and test yourself according to the Performance Checklist at the end of the reading unit.
2. View Trainex film, "Local Applications of Heat and Cold."
3. Attend lectures and demonstrations for heat and cold applications as scheduled by the instructor. Participate in group discussions.
4. Practice the procedure of Administration of Tepid Bath with a classmate in the lab area, or use the laboratory mannequin.
5. Perform a return demonstration for your instructor.
6. Have your instructor evaluate your performance.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 2: ADMINISTER WARM SOAKS

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Position patient in appropriate position for treatment.
5. Protect bed linen during treatment.
6. Fill appropriate basin one-half full with proper solution which has been tested for temperature.
7. Lower the part of the patient's body slowly into the solution; cover to conserve heat.
8. Maintain the proper temperature by adding more solution after the body part has been removed from the basin; place body part back in solution.
9. Check patient's skin during treatment.
10. Pat patient dry.
11. Clean and store equipment.
12. Report procedure and patient's response.

Test

Items Needed:
1. Protective sheet
2. Basin
3. Solution
4. Bath thermometer

Task: Apply moist heat in the form of a warm soak.

Standard: The designated area must be immersed the prescribed length of time at the prescribed temperature without burning the patient.

Learning Activities

1. Read pages 305-306, Being a Nursing Aide, 2nd Ed.

2. Review the vocabulary list for heat and cold applications on the Information Sheet with this task.

3. Watch the filmstrip by Trainex, "Local Applications of Heat and Cold."

4. Ask your instructor to explain or to demonstrate any part of the procedure you to not understand.

5. Practice the procedure using the laboratory mannequin or a classmate.

6. Identify, in small groups, patient-care situations that might require this treatment. Discuss your findings with your instructor.

INFORMATION SHEET
IV-C-2

Hot and Cold Applications Vocabulary

1. hypothermia - body temperature below normal range (hypo - less, below; thermia - temperature).

2. hyperthermia - body temperature above normal range (hyper - more, above).

3. infrared lamp - a special device that has light rays beyond the red end of the visible light spectrum.

4. metabolism - the entire process by which the body is nourished, maintained and provided with energy.

5. ultraviolet lamp - a special lamp that emits light rays outside the visible spectrum at the violet end.

6. principle of warm application - the blood vessel dilated (made bigger) by heat applications. The blood flow and white blood cells are increased in area of application.

7. principle of cold application - the blood vessel is constricted (made smaller) by cold applications. The blood flow is reduced in the area of application.

8. generalized applications - applying warmth or cold to the patient's entire body.

9. localized applications - applying warmth or cold to a specific part or area of the body.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 3: ADMINISTER SITZ BATH

Performance Checklist

1. Check physician's orders.
2. Identify patient and explain procedure.
3. Wash hands
4. Assemble equipment. (Sitz chair, portable Sitz, or bathtub may be used.)
5. Prepare water at 100°-110°F. (37.7°-43.3°C)
6. Provide foam ring, if indicated.
7. Assist patient into Sitz bath.
8. Keep water at constant temperature for prescribed length of time.
9. Assist patient out of Sitz bath.
10. Assist patient to dry and dress, as necessary.
11. Provide for patient's comfort.
12. Clean and store equipment.
13. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Sitz chair, portable Sitz or bathtub
4. Foam ring
5. Towels
6. Bath thermometer

Task: Assist the patient with a Sitz bath.

Standard:
1. Water temperature must be prepared and maintained at 100°-110°F (37.7°-43.3°C).
2. The Sitz bath must continue for the prescribed length of time.
3. The patient must be assisted into and out of the Sitz bath without undue discomfort and observing safety measures.

Learning Activities

1. Read pages 196-197, Nursing Skills for Allied Health Services, Vol. I, 1st ed. (pp. 253-254, Vol. I, 2nd ed.) and/or pages 9-39 to 9-40, Being a Nursing Aide, 1st ed. (pp. 315-318, 2nd ed.).

2. Observe a demonstration of this procedure when scheduled by your instructor. You should review vocabulary and safety precautions pertaining to heat applications.

3. Practice the procedure in the skill laboratory using the mannequin. Test yourself using the Performance Checklist provided with this task.

4. Identify, in small groups, patient-care situations in which this treatment might be prescribed. Compile a list and check it with your instructor.

5. Role play a patient-care situation in which a patient needs an explanation of this treatment and why it has been prescribed for him/her. Participate as a patient and as a member of the nursing team.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 4: APPLY HEAT LAMPS

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Provide privacy.
5. Expose only the part of body to be treated and direct heat to designated skin area.
6. Keep lamp about 18" from skin.
7. Check skin area during treatment.
8. Continue treatment only as long as directed.
9. Report procedure and observations.

Test

Items Needed:	1. Patient 2. Heat lamp
Task:	Apply a heat lamp to an area designated by your instructor.
Standard:	1. The heat must be directed to local area without burning the patient. 2. The time element must be observed. 3. The lamp must be kept approximately 18" from skin.

Learning Activities

1. Read and learn the Safety Checklist pertaining to heat applications included on Information Sheet with this task.

2. Read pages 13-11 and 13-12, Being a Nursing Aide, 1st Ed. (pp. 312-313, 2nd Ed.).

3. Attend a demonstration of this procedure when scheduled by the instructor.

4. Practice this procedure in the lab area, using the mannequin.

5. Perform this task for your instructor's evaluation.

INFORMATION SHEET
IV-C-4

Safety Checklist for Heat Applications

Suggested Time Checks for Heat Application:

Check the application often to keep it at the right temperature throughout the treatment. Suggested times for checking the temperatures of different kinds of applications are:

1. Every five (5) minutes - soak and intermittent compresses.
2. Every ten (10) minutes - heat lamps.
3. Every thirty (30) minutes - continuous compresses.
4. Every hour - warm water bottles and ice bags.

Keeping the Patient Safe:

1. Be sure the patient is not in a position where he might fall.

2. Check the patient's skin under warm applications.

3. Watch for too much redness.

4. Look for a darker discoloration that might mean the patient is being burned.

5. Listen when the patient complains.

6. If you think a patient is being burned, remove the heat application immediately and call your head nurse or team leader.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 5: APPLY HEATING PADS

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Turn on and check heating pad with hand.
4. Explain procedure.
5. Instruct patient in safety precautions.
6. Place electric pad on designated area, making sure that there is one layer of material between pad and patient.
7. Check skin during and after treatment.
8. Remove electric pad at end of treatment.
9. Report procedure.

Test

Items Needed:
1. Patient
2. Electric heating pad and cover

Task: Apply dry heat with an electric heating pad to an area designated by your instructor.

Standard:
1. All safety precautions must be observed.
2. The pad must be applied to the designated area.
3. The procedure must be performed without burning the patient.

Learning Activities

1. Read pages 626-627, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 579-580, Vol. II, 2nd Ed.).

2. Review and discuss with a classmate Safety Checklist for Heat Applications on Information Sheet included with Task 4 (Apply Heat Lamps).

3. Observe a demonstration of this procedure by the instructor, then practice the procedure in the class lab area using the laboratory mannequin.

4. Have your instructor evaluate your performance in the simulation of this task.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 6: APPLY LOCAL HEAT APPLICATIONS

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Place patient in comfortable position.
5. Protect bed linen during treatment.
6. Lubricate skin with petroleum jelly around area to be treated.
7. Check temperature of solution with solution thermometer; temperature should not exceed 115°-120°F or 47°-49°C.
8. Dip compresses in solution; wring out; and apply to area to be treated.
9. Cover with plastic wrapping or towel to maintain heat.
10. Reheat compresses by dipping again.
11. Check area frequently for signs of redness.
12. After completion of treatment, wash off petroleum jelly.
13. Dry patient.
14. Clean and replace equipment.
15. Report procedure and patient's response.

Test

Items Needed:
1. Patient
2. Basin
3. Compresses
4. Petroleum jelly
5. Protection sheet
6. Bath thermometer
7. Solution
8. Wash cloth
9. Towel
10. Soap

Task: Apply moist heat in the form of a heat compress as directed by your instructor.

Standard:
1. All safety precautions must be observed.
2. The heat compress must be applied to the designated area.
3. The procedure must be performed without burning the patient.

Learning Activities

1. Read pages 13-7 and 13-8, Being a Nursing Aide, 1st Ed. (pp. 300-302, 2nd Ed.).
2. View again the Trainex film, "Local Applications of Heat and Cold." Refer to any notes you have on this procedure.
3. Attend lecture and/or demonstration by your instructor on heat compresses. Ask questions about any part of the procedure you do not understand.
4. Review the safety checklist and the vocabulary list in this unit. Discuss with the instructor the rules which most apply to this procedure.
5. Practice the procedure of applying heat compresses in the class lab, using the laboratory mannequin or a fellow student as the patient. Check yourself according to the Performance Checklist for this task.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 7: APPLY HEAT PACKS

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Mix the contents of the package completely according to instructions on packet.
5. Apply heat pack to designated area.
6. Check patient's skin at intervals for changes in redness, swelling, pain, and blood circulation every fifteen (15) minutes.
7. Check to see that heat is working.
8. Dispose of pack when cold.
9. Replace pack when appropriate.
10. Remove pack after ordered time.
11. Report procedure and observations.

Test

Items Needed:
1. Patient
2. Heat pack

Task: Apply a heat pack to an area described by your instructor.

Standard:
1. The contents must be mixed thoroughly so that heat is working.
2. The pack must be applied to the designated area without burning the patient.

Learning Activities

1. Read pages 311-312, Being a Nursing Aide, 2nd Ed.

2. Read pages 620-622, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 582-583, Vol. II, 2nd Ed.). Discuss the procedure with a classmate.

3. Watch a demonstration by your instructor illustrating the use of various commercial heat packs. Read carefully the directions that accompany these commercial units.

4. Practice the procedure in the class lab and check yourself, using the Performance Checklist for this task.

5. Identify, in small groups, patient-care situations that might require the prescription of this treatment. Check your lists with your instructor.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 8: APPLY HOT WATER BOTTLE

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Fill hot water bottle 1/2 to 2/3 full of water. (105°-120°F or 40.5°-49°C)
5. Expel excess air from hot water bottle.
6. Check temperature with thermometer or by placing it against inner forearm.
7. Place hot water bottle on affected area with one layer of covering between bottle and patient.
8. Position patient so heat is not confined.
9. Check patient's skin at intervals. (10-20 minutes)
10. Remove hot water bottle; empty and allow to dry. Leave air in bottle to keep sides from sticking together.
11. Report procedure and patient's response.

Test

Items Needed:

1. Patient
2. Hot water bottle
3. Protective cover
4. Hot water
5. Bath thermometer

Task:

1. Fill hot water bottle.
2. Apply hot water bottle to an area designated by your instructor.

Standard: The hot water bottle must be applied to the designated area without burning the patient even if the bottle should break.

Learning Activities

1. Read pages 618-620, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 580-581, Vol. II, 2nd Ed.).

2. Observe demonstration of this procedure by the instructor.

3. Practice this procedure in the classroom lab and ask a classmate to critique your technique. Refer to checklist, if necessary.

4. Perform a return demonstration for your instructor. Make note of his/her suggestions.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 9: APPLY LOCAL COLD APPLICATIONS

Performance Checklist

1. Check physician's order for type of cold application.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Wash hands.
5. Provide protection for bedding, if indicated.
6. Prepare cold applications as follows:
   - a. Activate chemical in dry pack by squeezing, shaking or kneading.
   - b. Fill ice cap, collar or bag 1/2 to 2/3 full with ice.
   - c. Place material for compress in iced water and squeeze well before applying to patient.
7. Apply cold to designated area.
8. Repeat steps 6 and 7, as necessary.
9. Tidy area.
10. Provide for patient's comfort.
11. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Bed
4. Protective sheet
5. Dry pack
6. Ice cap, collar or bag
7. Towel
8. Material for compress

Task: Administer a cold application to the designated area on the patient.

Standard:
1. The cold application must cover the entire designated area.
2. The application must not wet the patient's bedding or clothing.
3. The application must remain in place the prescribed length of time.

Learning Activities

1. Read pages 3-18 and 3-19, Being a Nursing Aide, 1st Ed. (pp. 302-304, 2nd Ed.).

2. Attend scheduled lecture and demonstration by the instructor concerning the principles, safety precautions and techniques of applying cold compresses.

3. Review and discuss in class the principles of applying cold, pages 624-626, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 575-576, Vol. II, 2nd Ed.).

4. Study and learn the Safety Checklist for Cold Applications included in this task.

5. Practice this procedure in the class lab using the laboratory mannequin.

INFORMATION SHEET
IV-C-9

Safety Checklist for Cold Applications

1. Check the patient's skin where cold is being applied.
2. If the area appears to be blanched, very pale, white or bluish, remove application and report immediately.
3. Time the application carefully and check the site of application at least every thirty (30) minutes.
4. Terminate the treatment in case of undue chilling or discomfort to the patient.
5. Carefully report and record the patient's tolerance of the application.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 10: APPLY ICE BAGS

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Fill ice bag 3/4 full.
4. Remove excess air.
5. Explain procedure.
6. Protect patient and bed linen from dampening.
7. Place ice bag on affected area with protective cover between bag and patient.
8. Check patient at 1 hour intervals, observing skin area for paleness or bluish tinge, for tingling and for loss of sensation.
9. Remove bag at end of treatment.
10. Empty and store bag.
11. Report treatment.

Test

Items Needed:
1. Patient
2. Ice bag
3. Protective cover
4. Ice

Task:
1. Fill the ice bag.
2. Apply ice bag to an area designated by your instructor.

Standard: The ice bag must cover the affected area and remain in place the prescribed length of time.

Learning Activities

1. Read pages 13-20 and 13-21, Being a Nursing Aide, 1st Ed. (pp. 308-311, 2nd Ed.).

2. Read pages 622-623, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 588-590, Vol. II, 2nd Ed.).

3. Review the Safety Checklist for Cold Applications in this Unit.

4. Observe a demonstration of these procedures by the instructor. Participate in a question period.

5. Practice these procedures in class lab area. Use the Performance Checklist for this task.

6. Have your instructor evaluate your performance of this simulated task.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 11: ROTATE PATIENTS USING TURNING FRAMES

Performance Checklist

1. Check physician's orders.
2. Check equipment for proper operation.
3. Wash hands.
4. Identify patient and explain procedure.
5. Double check frame's safety devices.
6. To turn patient from his/her back to his/her abdomen:
   a. Prepare anterior frame.
   b. Place anterior frame over patient.
   c. Secure anterior frame.
   d. Adjust safety belts.
   e. Turn patient. CAUTION: Never turn patient alone. At least one person should be at each end of the turning frame when the patient is turned.
   f. Remove posterior frame.
   g. Adjust patient's body alignment.
7. Provide for patient's comfort and safety.
8. Record procedure.

Test

Items Needed:	1. Patient 2. Physician's orders 3. Turning frame 4. Safety belts 5. Co-worker(s)
Task:	Rotate this patient from the back to the abdomen.
Standard:	Immobilization of affected body parts must be maintained without undue pain or discomfort.

Learning Activities

1. Read, as available, pages 218-223, Fundamental Skills In Patient Care, and/or pages 44-46,48, Clinical Nursing Techniques, 3rd Ed., and/or pages 233-237, Simplified Nursing.

2. See filmstrip "Care of the Patient in Cervical Traction - Part II (Stryker Frame)"- TRAINEX - #SN151.

3. Visit Physical Therapy Department of your teaching hospital for demonstration of Stryker Frame.

4. Practice the use of the turning frames in the clinical setting. Work in small groups under the supervision of your instructor.

5. Have your instructor evaluate your performance of the task and continue to supervise you until all standards have been adequately met.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 12: OPERATE CIRC-O-LECTRIC BED

Performance Checklist

1. Check physician's orders.
2. Wash hands.
3. Explain procedure and turning schedule to the patient.
4. Prepare anterior frame.
5. Remove top covers from patient.
6. Attach anterior frame.
7. Turn patient.
   a. Press "FACE" position on control box.
   b. Turn patient slowly to prone position.
8. Remove posterior frame.
9. Adjust patient to proper body alignment.
10. Replace covers over patient.
11. Provide for patient's comfort and safety. CAUTION: Be sure to place safety or restraining belts on patient. Siderails cannot be used in the prone position.
12. Record procedure.

Test

Items Needed:
1. Patient in the supine position.
2. Circ-o-lectric bed
3. Physician's orders
4. Safety or restraining belts

Task: Use the bed to turn the patient to the prone position.

Standard:
1. The patient's body alignment must be maintained.
2. All safety precautions must be observed to insure the patient's comfort and safety.

Learning Activities

1. Read pages 220-221, Fundamental Skills in Patient Care, and/or pages 44,47, 48, Clinical Nursing Techniques, 3rd Ed.

2. View filmstrip "Nursing Care of the Patient in Cervical Traction - Part I (Circ-o-lectric Bed)"- TRAINEX #SN 151

3. Visit Physical Therapy Department for demonstration of Circ-o-lectric Bed.

4. a. Read Information Sheet IV-C-12 (Example of Institutional Policy and Procedure Regarding the Use of the Circ-o-lectric Bed).
   b. In small groups, discuss any similar procedure description for this task that your teaching hospital may provide.
   c. Practice the task, under the supervision of your instructor. Add additional "Points of Emphasis" to the Information Sheet as necessary.

5. Have your instructor supervise this task and evaluate your performance in:
   a. a simulated patient care situation.
   b. an actual patient care situation.

INFORMATION SHEET
IV-C-12

An Example of Institutional Policy and Procedure Regarding the Use of the Circ-o-lectric Bed

POLICY:

Circ-o-lectric bed is provided for patients with paraplegia, quadraplegia, extensive burns and/or fractures, and also for patients who require maximum nursing care.

It is usually done to immobilize patient or to allow greater mobilization depending on the patient's condition.

Controls should not be within patient's reach. A nurse must be with patient during the use of controls to avoid any accident. This nurse must be well informed on the mechanics of this bed.

EQUIPMENT:

Circ-o-lectric Bed, complete - From Sterile Processing Storage Area

PROCEDURE:	POINTS OF EMPHASIS:
A. 1. Prepare and test the bed before taking it into the room.	A. To move the patient may require the services of the attending physician or Physiotherapy personnel.
2. If patient's condition permits, explain the procedure carefully. Demonstrate all aspects of the circ-o-lectric bed, stressing those which apply to the patient.	
3. Transfer the patient onto the posterior frame.	
4. Center the patient's hips on the posterior frame.	
5. Position the footboard.	
B. 1. Turning the patient - show him the face plate, describing how it can be adjusted to support his head comfortably.	
2. If the patient is thick through the stomach and chest areas, place a pillow over his legs. Additional pillows may be used to maintain patient alignment and achieve stabilization.	

Information Sheet IV-C-12 (Continued)

PROCEDURE: (Continued) POINTS OF EMPHASIS: (Continued)

B. 3. Position the frame on the patient by first aligning the fittings at the head of the bed. The frame can be handled by one person, but its size and the degree of control necessary to position it correctly call for good body mechanics.

4. To avoid flexion of the head, adjust the face plate so it supports the patient's forehead and chin, then fasten the top end of the frame securely.

5. After positioning the footboard which is part of the anterior frame, lower the anterior frame so that there is enough pressure on the patient to have him feel secure during rotation. Tighten the bolts.

6. If able, have him grasp the anterior frame, this gives him an added sense of security. In some cases, straps are used as an additional safety measure.

C. 1. Turning patient to prone position - Before turning the patient to the prone position to complete his nursing care, explain that a frame will be placed securely on him and that he will be turned vertically at a slow, even rate.

2. The switch has a toggle which can be in two positions - "face" and "back". When in the "face" position, by pressing the switch, the bed will move in a vertical arc with the patient's head rising while his feet descend. This will rotate the patient to the prone or face-down position.

Information Sheet IV-C-12 (Continued)

PROCEDURE: (Continued) POINTS OF EMPHASIS: (Continu

C. 3. When the toggle is in the "back" position, the bed will move back through the same semi-circular arc until the patient is supine.

4. By applying constant pressure to the switch while the toggle is in the "face" position, the bed will rotate slowly and uniformly. This slow turning is to prevent the patient from experiencing vertigo.

5. Chat with the patient while he is being turned. Questions which call for a response may allow you to know something of his condition, and may help calm him, especially through his first few turnings.

6. An automatic stop on the inner side of the frame prevents the patient from going too far beyond the level prone position. However, lower the head to 10° in order to release the safety bar.

7. Pull the safety bar forward, level the bed.

8. To raise the posterior section, remove the head-end nut.

9. Engage it with the safety bar. This locks it in position.

10. Provide arm supports, with either side rails and pillows or arm slings, or pillow on table.

D. 1. Nursing Care - With the patient in a prone position, many nursing care procedures such as cleansing and rubbing of the back can be administered. Additional range of joint motion exercises may also be given.

Information Sheet IV-C-12 (Continued)

PROCEDURE: (Continued) POINTS OF EMPHASIS: (Continued)

D. 2. By placing a table under the patient, he can feed himself with a minimum of difficulty. If the applied weights and the prone position make jaw movement difficult, make arrangements for a diet that is easily chewed.

3. Position and prepare the food on the tray so the patient can serve himself. Let him know he may signal you if further assistance is needed.

4. By conveniently arranging the necessary articles, the patient can brush his teeth.

5. By placing a book on the table, you allow the patient to read in this position. If supine, he may read by using prism glasses. Providing diversionary activities helps to relieve the patient's boredom and is important since limited mobility of the head is often frustrating.

6. To relieve anxieties the patient may have about voiding in a flat position----

7. The bed may be tilted at a slight angle. Although the spinal column remains immobile, the changing of the patient's position to planes other than horizontal facilitates voiding. For elimination, a section of the posterior frame may be removed and a pot inserted.

Information Sheet IV-C-12 (Continued)

PROCEDURE: (Continued)

POINTS OF EMPHASIS: (Contin)

D. 8. Many nursing measures must be adapted to fit with the patient's turning schedule. For example, the anterior surface of the patient is bathed while he is supine; the rest of the bath will be given after turning. Since constant traction often implies long periods of immobility, foam rubber wedges or synthetic sheepskins may be used to inhibit skin breakdown.

9. Allow the patient to help with his bath as much as possible. Being dependent, he needs to feel independent. Being partially immobile, he needs to use whatever mobility his condition and treatment will allow.

10. Bathing is an opportune time to check for neurological impairment. Ask the patient if he has experienced any numbness or tingling sensations.

11. Use of the bed pan -
    a. Remove the circular metal plate with the attached mattress section.
    b. Place pan in position.
    c. Adjust patient to comfortable level.

E. 1. Turning patient to supine position - before the patient is turned back to the supine position, inspect the posterior frame cover for cleanliness, dryness and tautness. Change it if necessary. Attention to this detail each time the frame is turned will help minimize skin problems for the patient.

2. For turning, release the posterior frame from the safety bar and lower it onto the patient's back.

Information Sheet IV-C-12 (Continued)

PROCEDURE: (Continued) POINTS OF EMPHASIS: (Continued)

E. 3. Tighten bolt and lock safety bar in place.

4. Position the toggle to back position and press button to return patient to supine position.

5. While in supine position, leave bed at 10° elevation, to overcome sensation of head being lower than rest of body.

EXAMPLE OF CHARTING:

Charting may be done on Patient's Progress Notes in SOAP form.
Date and Time.

S - Patient's statement of need, if any.

O - Nurse's observation regarding need.

A - Assessment of patient's condition and action taken including patient's reaction and teaching done.

P - Plan of care; i.e., turning schedule based on patient's treatment and needs, etc.

Place nursing orders, as indicated, on flow sheet.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module C: Application of Environmental Treatments

Task 13: SET UP CHILD-ADULT MIST TENT

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Wash hands.
4. Identify patient and explain procedure.
5. Prepare patient's bed.
6. Secure mist tent frame.
7. Secure mist tent over bed.
8. Fill ice chamber with ice. NOTE: Some mist tents are equipped with refrigeration units.
9. Fill nebulizer jar 3/4 full with distilled water and replace to nebulizer.
10. Flush tent with oxygen and/or compressed air. CAUTION: Use appropriate safeguards.
11. Adjust flow to prescribed level.
12. Provide for patient's comfort and safety.
13. Record procedure.

Test

Items Needed:

1. Patient
2. Physician's orders
3. Mist tent
4. Mist frame
5. Ice chamber
6. Ice
7. Nebulizer
8. Distilled water
9. Oxygen
10. No Smoking sign
11. Compressed air

Task:

1. Set up the mist tent for a child or adult.
2. Flush tent with oxygen.
3. Flush tent with compressed air.

Standard:

1. The frame and tent must be secured.
2. The oxygen flow must be adjusted to the prescribed level.
3. The compressed air flow must be adjusted to the prescribed level.

Learning Activities

1. Read pages 533-540, Principles and Techniques in Pediatric Nursing; and/or pages 70-71, Textbook of Pediatric Nursing, 5th Ed.

2. View filmstrip "Oxygen Administration" - TRAINEX #PC 142.

3. Visit Respiratory Therapy Department for demonstration of Croupette preparation.

4. Practice with available equipment and infant mannequin in the laboratory.

5. Read Information Sheet IV-C-13 (Example of Institution Policy and Procedure Regarding the Use of a Croupette). Discuss any similar procedure that your teaching hospital may provide for the use of a croupette or mist tent.

6. Have your instructor evaluate your performance in:
   a. a simulated patient care situation
   b. an actual patient care situation
      (1) involving a pediatric patient
      (2) involving an adult patient.

INFORMATION SHEET
IV-C-13

Example of Institution Policy and Procedure Regarding the Use of a Croupette

POLICY:

A croupette is usually assembled by cardio-pulmonary personnel. In their absence, an RN or an LPN with the help of a nursing assistant, may assemble and start the procedure using the croupette.

EQUIPMENT:

From Department	From Cardio-Pulmonary Dept. (Requisition Required)
2 bath blankets	Croupette Frame
1 small sheet	Canopy
	Flow Meter

PROCEDURE:	POINTS OF EMPHASIS:

1. Take equipment to unit.
2. Assemble croupette frame on bed.
3. Attach canopy to frame.
4. Place bath blanket under croupette.
5. Tuck edges of canopy under mattress.
6. Attach flow meter to wall outlet.
7. Connect croupette oxygen tubing to flow meter and set rate 10 liters per minute and turn on oxygen.
8. Fill mist jar on croupette with distilled water.
9. Fill ice chest with ice.
10. Place drainage tubing, on outside of croupette, in bottle on floor.
11. Place baby in croupette.
12. Check croupette for temperature and excessive moisture.
13. Drain ice chest and refill, PRN.
14. Change bedding frequently.

Information Sheet IV-C-13 (Continued)

EXAMPLE OF CHARTING:

1. Note initial set up in SOAP form on Patient's Progress Notes.

S - Patient's statements, reactions, comments, if any.

O - Observations, signs, symptoms, lab and x-ray results indicating need for croupette.

A - Interpretation of S & O.
Progress of condition.
Pertinent information regarding procedure.

P - In Care Plan: Comfort measures
Best approach
Assessment

2. Subsequent comment, duration in croupette, etc. on Flow Sheet.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENT AND PROCEDURES

Module C: Application of Environmental Treatments

Task 14: SET UP VAPORIZER

Performance Checklist

1. Check physician's orders.
2. Wash hands.
3. Assemble equipment and supplies.
4. Identify patient and explain procedure.
5. Fill vaporizer to prescribed level with water. NOTE: Add medication, if applicable.
6. Connect vaporizer to electrical outlet.
7. Direct vapor stream above patient. *NOTE*: *Use extreme caution*.
8. Provide for patient's comfort and *safety*.
9. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Vaporizer (Inhalator)
4. Water
5. Medication

Task: Set up the vaporizer.

Standard:
1. The vaporizer must be filled to the prescribed level with water (and medication, if prescribed).
2. The vapor stream must be directed for maximum efficiency.
3. An adequate explanation *must* be followed by frequent checks for the *safe* use of this equipment.

Learning Activities

1. Read pages 412-413, *Fundamental Skills in Patient Care*.

2. Read Information Sheet IV-C-14 (Example of Institution Procedure and Policy Regarding the Use of a Steam Inhalator or Vaporizer).

3. Visit Respiratory Therapy Department for demonstration of vaporizer set up.

4. Practice with available equipment in the laboratory setting.

5. Have your instructor evaluate your performance of this task in the clinical setting.

INFORMATION SHEET
IV-C-14

Example of Institution Prodecure and Policy Regarding the Use of a Steam Inhalator or Vaporizer

POLICY

Steam inhalation is ordered by the doctor to relieve the patient's congestion and coughing, and to loosen secretions and stimulate his expectorating.

EQUIPMENT:

Inhalator (Vaporizer) from Central Processing, by requisition. Medication, if ordered from Pharmacy, by requisition. Stool to place inhalator on.

PROCEDURE:	POINTS OF EMPHASIS:
1. Raise the clamping arms and swing them to the right or left, the water bottle and medicine cup may be removed for filling.	
2. Replace medicine cup with prescribed medication in boiler, and swing steam dome back to operating position.	
3. Fill the bottle with hot water, and replace in inverted position.	
4. Take equipment to bedside; and explain procedure to patient.	4. Instruct patient in precautions to prevent burning.
5. Avoid drafts. Close windows.	
6. Place inhalator in convenient location. Turn bakeolite tube toward patient.	
7. Plug unit into electrical outlet. raise right hand switch to "on" and raise left hand switch for high steam volume. Vapor will appear in approximately five minutes. If full volume of vapor is not desired, place left hand switch in lower position.	

Information Sheet IV-C-14 (Continued)

PROCEDURE: (Cont.) POINTS OF EMPHASIS (Cont.)

8. Give treatment for twenty minutes, unless otherwise ordered.

9. Have patient remain in bed for one hour after treatment is completed.

CHARTING:

1. Chart first treatment in SOAP form.

S - Patient's statement or complaints.

O - Signs, symptoms, x-ray results, etc.

A - Interpretation of S & O
Pertinent information regarding procedure (type and amount of medication, duration) How tolerated by patient.
Progress of condition.

P - In Care Plan: Assessment to be done.
Approach most effective.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module D: Application of Bandages and Supports

Task 1: APPLY ACE BANDAGES

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. When wrapping an extremity, elevate it to level of heart.
5. Position patient comfortably.
6. Apply bandage with firm, even pressure, anchoring at beginning and avoiding wrinkles. Wrap from distal to proximal part of extremity.
7. Make sure area is completely covered with bandage.
8. Anchor end of bandage.
9. Check pulse or observe skin color to see if circulation is adequate.
10. Report procedure.

Test

Items Needed:	1. Patient 2. Ace bandage
Test:	Apply an ace bandage to a patient on an area designated by your instructor.
Standard:	1. The bandage must be wrapped with the proper tension. 2. The patient's circulation must be adequate.

Learning Activities

1. Read pages 675-678, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 637-638, Vol. II, 2nd Ed.) and/or pages 345-346, Being a Nursing Aide, 2nd Ed. Make notes of the key points.

2. Watch "Application of Bandages and Binders", filmstrip by Trainex.

3. Study the vocabulary list and the Checklist for Application of Bandages and Binders included in this task.

4. Enter new terms in your vocabulary notebook.

5. Observe a demonstration by your instructor.

6. Practice applying ace bandages on a classmate. Check your procedure, using the procedure checklist for this unit.

7. Have your instructor evaluate your performance. Make note of his/her suggestions.

SELF-CHECK LIST
IV-D-1

Application of Bandages and Binders

Usually used to:

1. Give support to a weakened body part.
2. Hold dressings and bandages in place.
3. Apply pressure to parts of the body to aid circulation or provide comfort.

Rules to Follow:

1. Keep the binder smooth and clean.
2. Watch for discolored areas on the patient's skin. Remove application Report these to your head nurse or team leader right away.
3. Use the correct type of binder. Be sure it is the correct size.

INFORMATION SHEET
IV-D-1

Bandages and Binders Vocabulary

I. Bandages

1. bandage - a piece of soft material, like gauze, used to wrap, bind, support, provide warmth for, protect or immobilize a part.

2. circular bandage - a bandage that is wrapped around and around a part; each turn covers the proceding turn and holds it securely in place; it is fastened with tape, a special holding clip or a safety pin.

3. elastic bandage - a bandage that is stretchable; when pulled tightly, it causes compression.(A commonly used elastic bandage is called the Ace Bandage.).

4. figure 8 bandage - a bandage in which the turns cross each other like a figure "8". Generally used over joints to retain dressings or to exert pressure in the case of sprains or hemmorhage.

5. recurrent bandage - used over the end of a stump of an amputated extremity, such as a leg or a finger.

6. reverse spiral bandage - special technique used in which a part of the bandage is folded back on itself to make it fit more uniformly (evenly); the reverse, or folding back, method may be used as part of each complete spiral or circular turn to make the bandage fit neatly over a difficult area (wrist, fingers or ankles).

7. roller bandage - a continuous strip of soft material (commonly gauze or elastic material) used to bind up injured parts. It comes in widths of 1/2 inch to six (6) inches, and lengths of two (2) to six (6) yards. The length and width you will use depends on the area to be bandaged.

8. spiral bandage - a bandage that consists of a series of circular turns ascending (going up) a part, such as from the fingers to the wrist; each turn is higher than the preceding one and overlaps the previous turns about half the width of the bandage.

9. triangular bandage - a bandage that is three-cornered, it holds dressings in place ; it is called a sling when used as a swinging bandage to support the forearm or elbow; it is most often used in this way.

II. Binders

1. binder - a bandage generally used to provide encircling support of the chest or abdomen, although it can be used in other situations.

2. abdominal binder - a single width of soft material eighteen (18) to twenty-four (24) inches wide and three (3) to five (5) feet long used to provide strong abdominal support.

3. breast binder - usually a sleeveless jacket-type--soft muslin binder used to hold breast dressings in place, support the breast or compress the breast as in the case of a new mother who is trying to dry up the milk in her breast.

4. scultetus binder - (many tailed) a succession of interlocking, overlapping bands used to enclose a part with rigid support, such as an abdominal girdle-like support following an abdominal operation.

5. T-binder - (sanitary belt) shaped like a letter "T", it is used to hold in place perineal pads as well as rectal or perineal dressings.

6. T-binder, double - shaped like a letter "T" except that it has two tails TT; commonly used for male patients who have had rectal or perineal surgery to hold the dressings in place.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module D: Application of Environmental Treatments

Task 2: APPLY ANTI-EMBOLIC STOCKINGS

Performance Checklist

1. Check physician's orders.
2. Obtain correct size stocking.
3. Identify patient and explain procedure.
4. Place patient in the supine position.
5. Gather one stocking from top to toe and apply stocking starting at patient's toes.
6. Pull stocking up slowly and evenly until stocking is completely applied. Avoid wrinkles.
7. Apply second stocking in the same manner.
8. Provide for patient's comfort.
9. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Anti-embolic stockings

Task: Apply anti-embolic stockings.

Standard:
1. The stockings must be the correct size.
2. The stockings must be applied without wrinkles.

Learning Activities

1. Read pages 728-729, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 501-502, Vol. II, 2nd Ed.). Discuss this section in small groups.

2. Attend lecture and demonstration relating to purpose and application of anti-embolic stockings scheduled by the instructor.

3. View the Trainex film, "Applications of Bandages and Binders" #436 and take notes if needed.

4. Practice applying anti-embolic stockings with a classmate in the class lab. Check yourself using the Performance Checklist for this task.

5. Role play a patient-care situation in which a patient is to have anti-embolic stockings applied for the first time. Be certain to include a patient explanation of this treatment.

6. Have your instructor critique your performance in this simulated situation.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module D: Application of Bandages and Supports

Task 3: APPLY BINDERS

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Wash hands.
4. Identify patient and explain procedure.
5. Place unfastened binder under patient.
6. Apply dressing or pad to affected area.
7. Close binder so that it provides snug, even pressure.
8. Record procedure.

Test

Items Needed:
1. Patient
2. Bed
3. Physician's orders
4. Binders
5. Dressing or pad

Task: Apply a binder to a designated area.

Standard:
1. The binder must provide snug, even pressure to the designated body area.
2. The binder must not interfere with adequate circulation or cause undue discomfort to the patient.

Learning Activities

1. Read pages 680-683, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 642-647, Vol. II, 2nd Ed.). Make a note of the key points.

2. Review the vocabulary and checklist included in this unit.

3. Observe your instructor's demonstration of the application of binders.

4. In the skill laboratory, with a partner, practice the correct procedure for applying a scultetus binder, breast binder, triangular bandage and an abdominal binder.

5. Have your instructor evaluate your performance of this task. You may be asked to apply any one of the binders listed.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module D: Application of Bandages and Supports

Task 4: IRRIGATE WOUNDS

Performance Checklist

1. Check physician's order.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Position and drape patient.
5. Wash hands.
6. Prepare equipment and irrigation solution.
7. Put on sterile gloves.
8. Drape wound site with sterile drapes.
9. Fill syringe with irrigating solution.
10. Connect irrigation catheter to syringe.
11. Insert catheter into wound.
12. Position receptacle to catch return flow of solution.
13. Inject solution.
14. Clamp catheter while you refill syringe and repeat procedure.
15. Remove catheter.
16. Observe returned solution for amount, color, odor and consistency.
17. Dry wound site.
18. Apply sterile dressing.
19. Provide for patient's comfort.
20. Remove equipment and supplies.
21. Tidy area.
22. Record procedure, pertinent observations, and patient's tolerance of treatment.

Test

Items Needed:

1. Patient
2. Physician's orders
3. Irrigation solution
4. Sterile gloves
5. Sterile drapes
6. Irrigation syringe
7. Catheter
8. Drainage receptacle
9. Towel
10. Sterile dressing

Task: Irrigate the designated wound.

Standard:

1. Instillation of the prescribed irrigation solution must be slow.

2. Record observation of the returned amount, color, odor and consistency.

Learning Activities

1. Read, as available, pages 303-307, Clinical Nursing Techniques, 3rd Ed. and/or pages 398-399, Fundamental Skills In Patient Care.

2. Differentiate between the positioning required for irrigation of (1) anterior wound, (2) posterior wound. Diagram such positioning, including wound location and draping, in your notebook.

3. Observe a demonstration of this procedure by your instructor.

4. Identify equipment used in this task and compare available disposable kits designed for such a treatment. Read carefully directions of disposable systems used at your teaching hospital(s).

5. Practice this task in the learning laboratory using the mannequin.

6. Practice charting pertinent observations related to this procedure. Use the Performance Checklist - #'s 16 and 22 as a guide.

7. Have your instructor evaluate your charting (recordings) in a simulated patient-care setting. Note suggestions.

8. Have your instructor evaluate your performance of the task (1) in the learning laboratory, (2) in an actual patient care situation.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module D: Application of Dressings, Bandages and Supports

Task 5: APPLY STERILE DRESSINGS/BANDAGES

Performance Checklist

1. Assemble equipment and supplies.
2. Identify patient and explain procedure.
3. Position patient for easy access to area to be bandaged.
4. Wash hands.
5. Remove soiled dressing/bandage.
6. Inspect area to be dressed/bandaged.
7. Wash hands again.
8. Open sterile supplies.
9. Put on sterile gloves.
10. Cleanse affected area.
11. Apply medication, if prescribed.
12. Apply sterile dressing/bandage.
13. Remove and dispose of gloves.
14. Apply tape or appropriate retainer to dressing.
15. Record procedure.

Test:

Items Needed:
1. Patient
2. Sterile supplies (dressings, bandages, etc.)
3. Sterile gloves
4. Medication
5. Equipment

Task: Apply a sterile dressing or bandage to a designated area.

Standard:
1. The dressing/bandage must completely cover the area of concern.
2. The dressing/bandage must not be contaminated in the process.
3. All items on performance checksheet must be rated adequate.

Learning Activities

1. Read pages 372-378, Fundamental Skills in Patient Care.

2. Observe filmstrip "Sterile Technique and Dressing Change" - TRAINEX.

3. Practice dressing change, using dressing kit or tray and mannequin.

4. Complete performance checksheet.

Name________________________
Date________________________

PERFORMANCE CHECKSHEET

Unit IV, Module D, Task 5

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Assemble correct equipment.		
2. Identify patient and explain procedure		
3. Position patient for efficient access to wound.		
4. Wash hands.		
5. Remove old dressing and dispose of.		
6. Re-wash hands.		
7. Open sterile supplies.		
8. Put on sterile gloves.		
9. Cleanse wound.		
10. Apply medication if ordered.		
11. Apply new sterile dressing.		
12. Remove gloves and dispose of.		
13. Apply tape or secure dressing.		
14. Chart procedure and observations.		

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module D: Application of Dressings, Bandages and Supports

Task 6: DRESS BURNS

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Wash hands.
4. Remove dressing and discard.
5. Put on sterile gloves.
6. Apply clean dressing.
7. Remove equipment and supplies.
8. Provide for patient's comfort.
9. Record procedure.

Test

Items Needed:
1. Burned patient
2. Dressings, bandages, etc.
3. Sterile gloves
4. Equipment

Task: Remove and replace a burn dressing.

Standard:
1. The dressing change must be accomplished without contaminating the burn site.
2. Pain and discomfort must be accurately assessed during the dressing change.
3. The dressing change must be completed without undue discomfort.

Learning Activities

1. Read **pages** 509-514, Basic Medical-Surgical Nursing, Mason, 3rd Ed.

2. Observe filmstrips "Medical Asepsis" - TRAINEX #PC 376.
   "Management of the Burned Patient" - TRAINEX.
   "Protective Isolation" - TRAINEX

3. Practice dressing change on mannequin, using dressing kit or tray.

4. Perform this task in a simulated situation described by your instructor.

5. Identify special applications for medical asepsis when caring for the burned patient. Discuss why these might be necessary.

6. Discuss, in small groups, how patients may respond to "protective isolation."

7. Participate in a demonstration/return demonstration laboratory session which illustrates various types of burn dressings.

8. Visit the Burn Unit of your hospital. Observe the total patient care plan for the various burn cases.

9. Discuss, with your class and instructor, the nurse's role in helping burn patients overcome anxiety about scars or other disfigurement.

10. Role play a situation described by your instructor involving:
    a. a child
    b. a young adult
    c. a mature adult

11. Have your instructor supervise and evaluate your performance of this task in several patient care situations.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module E: Drainage, Tubes and Irrigation

Task 1: ASSIST WITH OR CONNECT CATHETERS AND TUBING TO DRAINAGE

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Connect drainage tube to catheter using sterile technique.
5. Provide tubing long enough for patient to move.
6. Position tubing over patient's thigh and secure with tape.
7. Allow drainage to flow evenly by proper positioning of tubing and bed.
8. Empty drainage container when full and at the end of every shift, while keeping drainage bag below bladder level.
9. Provide for safety and comfort of patient.
10. Report any abnormal conditions.

Test

Items Needed:
1. Patient with a Foley catheter
2. Drainage bag
3. Drainage tube
4. Bed

Task: Connect catheters and tubing to drainage using a sterile technique.

Standard:
1. The tubing must be positioned so that drainage will flow evenly.
2. The tubing must be long enough for patient to move freely in bed.
3. There must be no tension or unnecessary pull on patient's skin.

Learning Activities

1. Read pages 418-421, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 318-322, Vol. I, 2nd Ed.) and/or pages 9-27 to 9-28, Being a Nursing Aide, 1st Ed. (pp. 226-227, 2nd Ed.).

2. Watch "Closed Urinary Drainage System" #343 by Trainex.

3. Attend the scheduled lecture and demonstration on catheters, tubing and drainage by the instructor. Ask questions if you do not understand.

4. Practice in the skill lab using the mannequin and ask a partner to critique your technique, using the Performance Checklist.

5. Have your instructor evaluate your performance of this task. Make note of instructor's suggestions on your checklist.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module E: Drainage, Tubes and Irrigation

Task 2: MEASURE AND RECORD CONTENTS OF GASTRIC AND INTESTINAL DRAINAGE BOTTLES

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Turn off suction momentarily.
5. Remove stopper.
6. Observe contents for color and consistency.
7. Pour contents into graduate and measure contents where appropriate.
8. Empty contents as instructed.
9. Clean bottle and replace rubber stopper.
10. Turn switch back to "on".
11. Record and report amount and characteristics of drainage.

Test

Items Needed:
1. Drainage bottles (with rubber stoppers)
2. Drainage tubes
3. Graduate

Task:
1. Measure and record contents of drainage bottles as instructed.
2. Empty the containers.

Standard:
1. The procedure must be completed without contamination.
2. Recorded observations must be without error.

Learning Activities

1. Read Pages 9-23 and 9-24, Being a Nursing Aide, 1st Ed. (pp. 287-289, 2nd. Ed.). Study"Rules to Follow."
2. Read pages 515-516, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 563-566, Vol. II, 2nd Ed.). Study this material and be prepared to participate in class discussion.
3. Attend scheduled lecture and demonstration pertaining to gastrointestinal tubes and suction machines.
4. In the skill laboratory, practice the procedure for this task with a classmate. Ask your instructor to critique or help you as you practice.
5. Review the vocabulary list included in this unit. (See Information Sheet IV-B-8.) Add new terms to your vocabulary notebook.
6. Complete the following test situation: Given a patient with a Gomoco suction apparatus and a 2/3 full drainage bottle, you will empty the bottle and attac it to the suction machine, using the procedure you have just learned. After finishing the bottle change, you will record the output and your observations on the appropriate records. You must be 100% correct.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module E: Drainage, Tubes and Irrigation

Task 3: PREPARE AND GIVE A VAGINAL DOUCHE

Performance Checklist

1. Gather equipment.
2. Wash hands.
3. Identify patient.
4. Prepare solution (temperature 105°F or 40.5°C).
5. Set up equipment.
6. Explain procedure.
7. Screen patient for privacy.
8. Have patient void.
9. Place bedpan under patient.
10. Prepare and position patient.
11. Drape appropriately.
12. Clean the labia with downward strokes.
13. Expel air from tubing.
14. Insert nozzle gently upward and backward and rotate while solution is flowing under low pressure (bag is held no higher than twelve (12) inches above patient).
15. Clamp off tubing.
16. Remove nozzle.
17. Let solution drain from patient.
18. Observe returned solution.
19. Dry patient.
20. Clean and store equipment.
21. Report procedure.

Test

Items Needed:
1. Patient
2. Vaginal douche kit
3. Protective sheet
4. Solution
5. Cotton balls
6. Bedpan

Task:
1. Prepare the patient.
2. Administer a vaginal douche.

Standard:
1. The patient must be accorded privacy.
2. The solution must be the proper temperature.
3. The solution must be instilled under low pressure.

Learning Activities

1. Review the vocabulary and the discussion on Perineal Care on pages 682-686, Nursing Skills for Allied Health Services, Vol. II, 2nd Ed. Be prepared to give written definitions for the vocabulary words.
2. Read pages 9-41 to 9-44, Being a Nursing Aide, 1st Ed.
3. Watch the filmstrip, "Peri Care" #342, by Trainex.

4. Attend the lecture and demonstration scheduled by your instructor.

5. Using the mannequin in the skill laboratory, practice the procedure.

6. Identify patient-care situations in which this treatment might be prescribed. Check your list with your instructor.

7. Discuss, in small groups, how to provide privacy and appropriate esthetics for this procedure. Describe the importance of privacy and adequate explanation in the administration of this treatment.

8. Role play a patient-care situation in which a patient will receive a vaginal douche for the first time. How might your explanation differ depending on the age of the patient? Have your instructor evaluate your performance.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module E: Drainage, Tubes and Irrigation

Task 4: PREPARE AND GIVE A CLEANSING ENEMA

Performance Checklist

1. Wash hands.
2. Assemble equipment.
3. Identify patient.
4. Prepare solution using water at 105°F or 40.5°C and other additives if specified or warmed oil.
5. Explain procedure.
6. Screen patient for privacy and protect bedding.
7. Set up equipment, positioning container twelve to eighteen (12-18) inches above the anus.
8. Position patient comfortably on left side with left leg straight and right leg flexed.
9. Lubricate rectal tube and expel air.
10. Insert rectal tube, slowly and gently about four (4) inches into rectum.
11. Instill solution slowly to prevent cramping and urge to expel solution.
12. Remove rectal tube and cover it with tissue.
13. Assist patient onto bedpan or help patient to bathroom; instruct patient to wait for ten (10) minutes before expelling solution or at least thirty (30) minutes for retention enema.
14. Remove bedpan and check contents.
15. Provide for patient's comfort and cleanliness.
16. Report observations and procedures.

Test

Items Needed:
1. Patient
2. Enema kit
3. Instructions for preparing the solution
4. Tissues
5. Cleaning and protection materials

Task:
1. Give a cleansing enema.
2. Give a retention enema.

Standard
1. The patient must be accorded privacy and comfort.
2. The solution must be proper temperature and instilled slowly.
3. The patient should retain solution for designated time.

Learning Activities

1. Read pages 450-454, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 397-401, Vol. II, 2nd Ed.) and/or pages 9-33 to 9-36, Being a Nursing Aide, 1st Ed. (pp. 210-216, 2nd Ed.).
2. Watch the Trainex film, "Cleansing Enema" PC 368.

3. Observe and listen as your instructor demonstrates and explains the procedure. Be prepared to ask questions and discuss the procedure.

4. Using the mannequin in the skill laboratory, practice the procedure for this task. Check yourself according to the Performance Checklist.

5. Review the vocabulary list on the Information Sheet included in this task. Enter new terms in your vocabulary notebook.

6. Watch the filmstrip a second time, if you think it would be helpful to you. Identify new terms used and enter in your vocabulary notebook. Have your instructor check your definitions.

7. Complete a demonstration of this task for your instructor, using the checklist as your guide.

INFORMATION SHEET
IV-E-4

Vocabulary

1. large bowel - (total length four (4) to six (6) feet in the adult).

2. anus - (anal) the outer opening of the rectum between the buttocks and beyond the lower tip of the sacrum.

3. appendix - a small wormlike pouch about 7.5 cm. long at the end of the cecum.

4. cecum - the pouch at the junction of the small intestine and the ascending colon with the appendix at the lower end.

5. colon - the large intestine from the cecum to the rectum, which is divided into the ascending colon, the transverse colon, the descending colon and sigmoid.

6. rectum - the lower part of the large intestine between the sigmoid and the anus, about five (5) inches long.

7. feces - the waste material following digestion; the stool.

8. flatus - gas in the digestive tract (flatulence is the distention of abdomen due to gas in the intestine).

9. stool - feces, the waste matter discharged from the bowel.

10. constipation - sluggish action of the bowels; compacting of the feces into a hard, dense mass.

11. defecation - the evacuation of the bowel.

12. diarrhea - frequent movement of the bowels, increased number of stools per day, often liquid or semiliquid.

13. sphincter - a circular muscle that opens and closes an opening, such as the sphincter of the anus.

Student Competency Sheet

Unit IV: ASSISTING WITH TREATMENTS AND PROCEDURES

Module E: Drainage, Tubes and Irrigation

Task 5: ASSIST PATIENT WITH POSTURAL DRAINAGE

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Arrange equipment.
5. Wash hands.
6. Position patient.
7. Instruct patient to cough up secretions and allow them to drain into receptacle.
8. Assist patient to loosen secretions by "vibrating" the patient or gently striking the patient between the shoulder blades with cupped hands.
9. If a sputum specimen is to be collected, follow the procedure below:
   a. Instruct patient on how to collect specimen.
   b. Collect specimen in proper container.
   c. Seal container. NOTE: Avoid contamination of hands and clothing.
   d. Wash and dry outside of container.
   e. Apply label to container.
   f. Arrange for delivery of specimen to lab.
10. Assist patient to regain position in bed.
11. Provide for oral hygiene.
12. Remove and clean equipment.
13. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's order for postural dranage
3. Emesis basin or other receptacle
4. Specimen container
5. Label
6. Toothbrush
7. Toothpaste
8. Cup of water
9. Towel

Task: Assist the patient with postural drainage.

Standard:
1. The patient must be positioned to promote drainage and prevent injury by falling.
2. The specimen must be collected, contained and sealed without contamination to specimen, you or the environment.

Learning Activities

1. Read Page 411, Fundamental Skills in Nursing Care.
2. Read pages 230-232, Basic Medical-Surgical Nursing.
3. View filmstrips: ""Postural Drainage, Clopping, and Vertebration" - TRAINEX #191 and/or "Postural Drainage" - Career Aids.
4. Visit Respiratory Therapy and observe postural drainage being done on a patient.
5. Observe postural drainage being administered in a patient's room.
6. Practice this procedure in the laboratory using a mannequin.
7. Have your instructor evaluate your performance in a simulated patient care situation.
8. Identify the significance of early patient teaching for continuing this procedure at home. What adaptations can be made in the home to administer this treatment? Discuss your conclusions and questions with your instructor and the physical therapist or respiratory therapist.

UNIT V

COORDINATING AND COMMUNICATING

Terminal Objectives

Upon completion of the modules in this unit, you will:

- Admit or discharge a patient.
- Itemize and secure a patient's valuables.
- Complete forms for release, consent for surgery and consent for treatment.
- Transfer a patient within the facility.
- Assist in placing telephone calls.
- Use the intercom.
- Arrange for a clergy's visit.

Student Competency Sheet

Unit V: COORDINATING AND COMMUNICATING

Module A: Admission, Transfer and Discharge Procedures

Task 1: ADMIT A PATIENT

Performance Checklist

1. Wash hands.
2. Prepare environment.
3. Assemble equipment and supplies.
4. Greet patient and introduce yourself.
5. Take patient to room and orient to environment.
    a. Explain applicable policies.
    b. Explain use of equipment.
6. Provide for patient's privacy.
7. Assist patient to undress and dress.

8. Secure patient's valuables and/or medications, if applicable.
9. Take vital signs.
10. Obtain routine specimens, if applicable.
11. Provide for patient's comfort and safety.
12. Record procedure and observations.

Test

Items Needed:
1. Patient
2. Bed
3. Admission forms
4. Bed garments
5. Valuables envelope
6. Thermometer
7. Stethescope
8. Sphygmomanometer

Task: Process the patient for admission to your unit.

Standard:
1. The procedure will be evaluated by your instructor using a Checksheet of Performance.
2. All items must be rated "acceptable."

Learning Activities

1. Read pages 555-561, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (p. 651, Vol. II, 2nd Ed.) and/or pages 11-1 to 11-6, Being a Nursing Aide, 1st Ed. (pp. 263-268, 2nd Ed.).

2. Role play, with fellow students, the admission of the following clients:
    a. An eighteen (18)-year old girl, no previous hospital admissions.
    b. An eighty-six (86)-year old man, hard of hearing and quite weak.
    c. A seven (7)-year old boy, no previous hospital admissions, frightened and curious.
    d. A forty-eight (48)-year old woman who is blind. She is the mother of six (6) children.

3. Participate both as a patient and as a member of the nursing team.

4. Watch filmstrip, "Admissions and Discharges" #374, by Trainex.

5. Complete performance checksheet.

Name________________________
Date________________________

PERFORMANCE CHECK

Unit V, Module A, Task 1

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Prepared environment.		
2. Greeted patient and made appropriate introductions.		
3. Oriented patient to room, equipment and policies.		
4. Provided for patient's privacy.		
5. Assisted with undressing and dressing.		
6. Secured patient's valuables and/or medications.		
7. Checked and recorded vital signs.		
8. Obtained or made arrangements for obtaining applicable routine specimens.		
9. Provided for patient's comfort and safety.		
10. Recorded procedure and observations.		

Student Competency Sheet

Unit V: COORDINATING AND COMMUNICATING

Module A: Admission, Transfer and Discharge Procedures

Task 2: TRANSFER A PATIENT WITHIN THE SAME FACILITY

Performance Checklist

1. Obtain request for transfer.
2. Wash hands.
3. Identify patient and explain procedure.
4. Provide for patient's comfort and safety.
5. Transport patient and personal items.
6. Introduce patient to new personnel.
7. Complete transfer forms and other necessary records.

Test

Items Needed:
1. Patient
2. Transfer forms
3. Agency policies
4. Wheelchair or stretcher

Task: Transfer the patient from one locale to another in the same facility.

Standard:
1. All personal items must be transferred to the new location.
2. The patient must be transported by the method prescribed.
3. All forms and records must be completed in accordance with policies.

Learning Activities

1. Read pages 561-563, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 434-436, Vol. II, 2nd Ed.) and/or pages 11-7 to 11-9, Being a Nursing Aide, 1st Ed. (pp. 268-270, 2nd Ed.).
2. Practice the procedure with fellow students in the laboratory.
3. Identify explanations that might be necessary for the patient and the patient's family when a transfer is ordered.
4. Discuss such explanations with your instructor and note his/her suggestions.
5. Have your instructor evaluate your performance of this task in the hospital setting.

Student Competency Sheet

Unit V: COORDINATING AND COMMUNICATING

Module A: Admission, Transfer and Discharge Procedures

Task 3: DISCHARGE A PATIENT

Performance Checklist

1. Check physician's order for patient's discharge.
2. Identify patient and explain procedure.
3. Notify all appropriate departments of patient's discharge.
4. Obtain personal items including valuables, medications, dressings, prescriptions or special health instructions.
5. Instruct patient in continued use of medications or appliances and convalescent procedures.
6. Check dressings, appliances, bandages, etc. Change, as necessary.
7. Assist patient to dress.
8. Obtain release from business office.
9. Transport patient to designated loading/unloading area.
10. Assist patient into vehicle.
11. Place patient's personal items in vehicle.
12. Return to room and make it ready for terminal cleaning.
13. Complete all necessary records.

Test

Items Needed:

1. Patient
2. Discharge orders
3. Agency policies
4. Discharge forms
5. Patient's personal items (valuables, medications, dressings, prescriptions or special health instructions)
6. Wheelchair

Task: Discharge the patient from the facility.

Standard:

1. The patient must be instructed in the continued use of medications, applicances, and convalescent procedures, as applicable.
2. Safe transportation of patient and belongings must be provided.
3. All discharge records must be completed in accordance with agency policies.

Learning Activities

1. Read pages 11-9 to 11-12, Being a Nursing Aide, 1st Ed. (pp. 271-274, 2nd Ed.) and/or pages 563-565, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 651, Vol. II, 2nd Ed.).
2. Review segment of Trainex filmstrip #374 dealing with discharge.
3. Practice the procedure with classmates in the laboratory.
4. Have your instructor evaluate your performance in the hospital setting.

Student Competency Sheet

Unit V: COMMUNICATION PROCEDURES

Module A: Admission, Transfer and Discharge Procedures

Task 4: SECURE PATIENT'S VALUABLES

Performance Checklist

1. When possible, request that a family member take valuables home.
    - a. Itemize and describe each item.
    - b. Carefully list number and denomination of each bill or coin when securing money.
    - c. Obtain signature and relationship of family member receiving valuables and place with patient's chart.
    - d. Record on Nurse's Notes.
2. If valuables are to remain in facility:
    - a. Obtain patient's hospital number from records or ID bracelet and place in appropriate area in Valuable Envelope.
    - b. Itemize and describe each item.
    - c. List number and denomination of each bill or coin when securing money.
    - d. Obtain patient signature on front of Valuables Envelope.
    - e. Place date and signature of person receiving valuables in spaces provided.
    - f. Person receiving valuables will detach receipt, seal envelope in presence of patient, and have patient sign his/her name across the seal.
    - g. Give valuables receipt to patient.

NOTE: Procedures for securing patient's valuables vary with every facility. Follow those outlined by your facility directives.

Test

Items Needed:
1. Newly admitted patient
2. Necessary forms to record and describe items.
3. Valuables Envelope, with receipt.

Task:
1. Itemize and describe patient's valuables on the appropriate forms.
2. Obtain necessary signatures.
3. Provide for safe storage of all items.

Standard:
1. The valuables must be itemized and described.
2. Appropriate signatures must be obtained.
3. The patient must feel secure regarding the safety of valuable property.

Learning Activities

1. Read pages 337-338, Fundamental Skills In Patient Care; pages 144-146, Total Patient Care, 4th Ed.

2. Attend a lecture/discussion session describing the policies for care of valuables in your teaching hospital(s)/agencies.

3. Review, in large or small groups, the forms, envelopes, and written policies used by nursing personnel in protecting the patient's money and/or valuable items.

4. From a selection of simulated patient care situations provided by your instructor, discuss the nurse's role in providing safety for valuable property and peace of mind for the patient.

5. Role play several patient care situations involving the nurse's role in securing patient's valuables. Participate as a patient and a member of the nursing staff. Have your instructor critique these performances.

6. As assigned by your instructor, perform this task in the clinical setting. Have your instructor evaluate your performance based upon the stated standards.

Student Competency Sheet

Unit V: COMMUNICATION PROCEDURES

Module A: Admission, Transfer and Discharge Procedures

Task 5: COMPLETE RELEASE FORMS

Performance Checklist

1. Make sure you have the correct form(s).
2. Enter pertinent information.
3. Identify patient and/or guardian and explain procedure.
4. Ask patient/guardian to read information.
5. Answer patient/guardian questions.
6. Obtain full patient/guardian legal signature, in ink.
7. Have signature witnessed.
8. Place form(s) on patient's chart.
9. Record procedure.

Test

Items Needed:
1. Authorization for release forms.
2. Consent for surgery forms.
3. Consent for treatment forms.
4. Patient.
5. Witness.

Task:
1. Complete the release forms.
2. Complete the consent for surgery forms.
3. Complete the consent for treatment forms.

Standard:
1. All pertinent information must be entered on the forms.
2. Forms must be completed with no errors.
3. The patient's (or guardian's) legal signature must be obtained and witnessed.
4. The patient must indicate that an adequate explanation has been provided.

Learning Activities

1. Review suggested readings listed in Task 4 of this module.

2. Read pages 20, 101, 437, and 439, Fundamental Skills In Patient Care.

3. Identify statements that patients may question, on example consent (release) forms supplied by your instructor.

4. List situations in which you have signed a consent (release) form for yourself or another person. Briefly describe your concerns and questions, at those times. Discuss these lists in small or large groups. How do such accounts help to develop empathy for the patient?

5. Role play, with fellow students, a situation in which a patient must sign a consent (release) form.

6. Have your instructor critique your role play.

7. Have your instructor supervise your performance of this task in the clinical setting and evaluate your performance on the basis of the standards listed in this task.

Student Competency Sheet

Unit V: COORDINATING AND COMMUNICATING

Module B: Communication

Task 1: ASSIST IN PLACING TELEPHONE CALLS

Performance Checklist

1. Inform patient of your desire to assist in making the call.
2. Place patient in comfortable position.
3. Obtain telephone number of party patient wished to call.
4. Dial number.
5. Identify yourself when party answers.
6. Give phone receiver to patient.
7. Place call signal within easy reach of patient.
8. Leave patient to talk in privacy.
9. Return to assist when patient signals.

Test

Items Needed: 1. Bed patient
2. Telephone

Task: Assist the patient in placing a personal telephone call.

Standard: The correct party must be reached.

Learning Activities

1. Read page 31, Being a Nursing Aide, 2nd Ed.
2. View, as available, the following filmstrips:
   a. "Ethics for the Nursing Assistant" - Career Aids
   b. "Nursing Staff Oral Communication" - Career Aids
   c. "Developing Skills in Communication" - Train-Aide
3. Practice the use of the telephone in the learning laboratory.
4. Identify the information that should be given when you answer the phone in a patient's room or in the nurses' station.
5. Have your instructor critique your performance of this task in simulated situations.

Student Competency Sheet

Unit V: COORDINATING AND COMMUNICATING

Module B: Communication

Task 2: USE THE INTERCOM

Performance Checklist

1. Answer intercom promptly and courteously.
2. Listen to patient's request.
3. Go to room if patient does not answer.
4. Reply distinctly and in polite manner.

Test

Items Needed:
1. Patient
2. Intercom

Task: Your instructor will provide two situations for you to answer the intercom.

Standard:
1. Answer the intercom promptly.
2. Speak clearly so that the patient can hear the message.
3. Be polite.

Learning Activities

1. Review any available filmstrips listed in the previous task.

2. In small groups, identify the problems that might arise for patients and/or staff unfamiliar with the use of the intercom.

3. Practice the use of the intercom with a partner, in the learning lab or hospital setting.

4. Role play a simulated situation of explaining the use of the intercom to a newly admitted patient. Participate as both a patient and as a member of the nursing team.

5. Have your instructor evaluate your performance of this task.

Student Competency Sheet

Unit V: COORDINATING AND COMMUNICATING

Module B: Communication Procedures

Task 3: ARRANGE FOR A CLERGY'S VISIT

Performance Checklist

1. Locate clergy representing patient's religious preference, if possible.
2. Make phone call.
3. Give name of facility, patient and room number.
4. State nature of patient's request, if necessary or appropriate.
5. Obtain name of clergy who will visit and approximate time.
6. Report back to patient and tell him who will visit and at what time.
7. Record activity and patient's response, if appropriate.

Test

Items Needed:

1. Patient who has requested the services of the clergy.
2. Telephone
3. Notepad
4. Pencil
5. Directory

Task: Arrange for the clergy to visit the patient.

Standard:

1. The visiting clergy may be from the patient's religious preference.
2. The communication process will attempt to provide comfort and reassurance to the patient and seek to meet the patient's needs.

Learning Activities

1. Read pages 217-222, Basic Patient Care, Anderson, or a reference suggested by your instructor; page 693, Nursing Skills for Allied Health Services, 2nd Ed. (1st Ed., page 387).

2. View filmstrip "Spiritual Needs of the Patient" - TRAINEX #155.

3. Identify, in small groups, particular times when clients may be especially likely to ask that a clergy be contacted. Share these lists with other groups and with your instructor.

4. Discuss the role of the clergy as a member of the health team. How can clergy be included in attempting to meet the needs of the total patient?

5. Attend a discussion/lecture which illustrates the involvement of the clergy in your teaching hospital(s). Hospital or institutional chaplains may be a part of this presentation.
6. Review hospital policy and procedure for telephone calls.
7. Have your instructor provide a simulated situation and evaluate your performance.

UNIT VI

MEDICAL AND SURGICAL ASEPSIS

Terminal Objectives

Upon completion of the modules in this unit, you will:

- Use proper aseptic methods to prepare equipment and supplies for sterilization.
- Follow proper isolation techniques in donning and removing gown, mask and gloves.
- Follow proper isolation techniques to serve and remove a diet tray.
- Follow proper isolation techniques to dispose of soiled material and perform terminal disinfection.
- Set up an isolation unit.
- Collect a specimen from an isolated patient.

Student Competency Sheet

Unit VI: MEDICAL AND SURGICAL ASEPSIS

Module A: Surgical Asepsis

Task 1: PREPARE EQUIPMENT AND SUPPLIES FOR STERILIZATION

Performance Checklist

1. Preparing linens (masks, gowns, sheets, towels) for sterilization:
   a. Inspect all linen for holes, tears, weak spots.
   b. Roll masks singly and pack loosely in metal containers or paper bags.
   c. Fold gowns lengthwise, wrong side out, roll from hem to neckband.
2. Preparing dressings for sterilization:
   a. Wrap compresses, applicator, cotton balls, in double muslin covers.
   b. Fold pads in half, smooth side inside, and wrapped singly in double muslin covers.
3. Preparing glassware (syringes, tubing, beakers, tips, jars) for sterilization:
   a. Inspect all glassware for cracks or chips.
   b. Wash with soap or detergent and water; rinse well.
   c. Clean inner surfaces with applicators.
   d. Syringes:
      (1) Match numbers on plunger and barrel.
      (2) Wrap plunger and barrel in gauze, separate surfaces by layer of gauze. Wrap each complete syringe in a double muslin cover.
   e. Tubing, beakers, tips:
      (1) Wrap in gauze to reduce breakage, then in double muslin covers.
      (2) When part of a sterile tray, always wrap in gauze.
4. Preparing instruments for sterilization:
   a. Wash instruments with warm, soapy water (brush the hinged or serrated parts).
   b. Rinse and dry, or place in instrument washer/sterilizer for washing and sterilization.
   c. Instrument trays:
      (1) Place a single thickness of linen in bottom of trays.
      (2) Open all hinged instruments.
      (3) Fill tray to within one-half inch of top (if more get larger tray) by alternating a layer of instruments with a layer of linen.
5. Preparing suture needles for sterilization:
   a. Wash and dry needles.
   b. Scour with non-abrasive scouring powder when necessary.
   c. Always clean toward point of needle.
   d. Arrange needles according to type on a piece of gauze or needle rack.
6. Preparing rubber goods (gloves, tubing, catheters, drains) for sterilization:
   a. Gloves:
      (1) Inflate gloves. Test for holes.
      (2) Lightly powder gloves inside and out (use glove powdering machine where available).
      (3) Segregate by size and sort into pairs.
      (4) Turn back a two (2) to three (3) inch cuff on each glove.
      (5) Place gloves inside muslin or paper glove holder.
      (6) Add packet of powder between folds of holder.
      (7) Wrap holder in a double muslin cover.
      (8) Write glove size on the outside wrapper.

b. Tubing:
    (1) Remove all clamps.
    (2) Wash tubing with warm soapy water; rinse (inside and out).
    (3) Place flat in a container, wrapper or tray; coil loosely without kinks.

7. Preparing suture materials for sterilization:
    a. Silk, cotton, nylon, linen:
        (1) Wrap suture material loosely about a piece of cardboard or cut into strands.
        (2) Place in a test tube and wrap in a double muslin cover.
        (3) Place in a treatment or instrument tray.
        (4) These sutures must be sterilized by steam because absolute sterility is essential.
    b. Suture material in hermetically sealed tubes:
        (1) Boilable: autoclave with treatment of instrument trays.
        (2) Non-boilable: wash tube with soap and water; rinse. Place in a covered container of disinfectant solution for eighteen (18) hours. Store in covered container of same solution.

Test

Items Needed:
1. Checklist specifying pack or tray contents
2. The checklist may designate:
    a. Linens
    b. Dressings
    c. Glassware
    d. Instruments
    e. Suture needles
    f. Rubber goods
    g. Suture materials

Task:
1. Assemble the designated equipment and supplies.
2. Set up the pack or tray for sterilization.

Standard:
1. The pack or tray must be labeled and dated.
2. The pack or tray must contain all items specified on the checklist.
3. All items must be arranged so that when the pack or tray is opened, those articles used first will be on the top.

Learning Activities

1. Read pages 3-1 to 3-12, Being a Nursing Aide, 1st Ed. (pp. 17-18 and 39-61, 2nd Ed.) and/or pages 51-57, Fundamental Skills in Patient Care, Lewis.

2. View, as available, the following filmstrips:

    a. "Asepsis - Medical and Surgical" - Lippincott film loops
    b. "Gown, Gloves, Mask - Single Use" - Lippincott film loops
    c. "Important Procedures in Asepsis" - Trainex, #379-Part I

3. Observe a demonstration, by your instructor, of the preparation of available equipment for sterilization.

4. Observe preparation of other materials (that may not be available in your learning laboratory) in the Central Supply or Central Processing Department of your teaching hospital.

5. Identify, with the help of your instructor, those items appearing on the Performance Checklist that are most frequently utilized as disposable items in health care institutions today.

6. Practice the preparation of available supplies in your learning laboratory.

7. In small groups, discuss the advantages and disadvantages of disposable vs. reusable sterile supplies - 1) to the patient; 2) to the nurse; 3) to the health care institution.

8. Summarize your group's conclusions and discuss them with your instructor.

Student Competency Sheet

Unit VI: MEDICAL AND SURGICAL ASEPSIS

Module B: Medical Asepsis

Task 1: FOLLOW PROPER ISOLATION TECHNIQUES (DON AND REMOVE GOWN, MASK AND GLOVES)

Performance Checklist

1. Don gown, mask and gloves.
    a. Remove watch and rings.
    b. Wash hands.
    c. Remove mask from container; place over nose and mouth and tie securely, top strings first.
    d. Hold gown at neck and let unfold.
    e. Put arms through sleeves, one at a time, touching only inside of gown.
    f. Adjust gown.
    g. Tie neck tapes.
    h. Bring gown together and tie waist belt.
    i. Obtain glove wrapper; lay on flat surface and unfold.
    j. Remove powder and powder hands if appropriate.
    k. Remove one glove from holder by grasping folded edge and place on hand. Repeat for second glove.
    l. Adjust gloves over gown and on fingers.
2. Remove gown, mask and gloves.
    a. Untie waist belt of gown and pull toward front.
    b. Wash hands.
    c. Untie neck ties.
    d. Remove mask by untying bottom strings first.
    e. Dispose of mask.
    f. Pull sleeves off one at a time without touching outside of gown.
    g. Remove gown and dispose of it properly.
    h. Remove one glove at a time. (Do not touch skin with dirty surface.)
    i. Dispose of gloves.
    j. Wash hands before and after leaving unit.

Test

Items Needed:
1. Isolation unit
2. Gown
3. Mask
4. Gloves
5. Powder

Task: Put on and remove gown, mask and gloves.

Standard:
1. The procedure must be performed without contamination.
2. All checklist items must be rated acceptable.

Learning Activities

1. Read pages 746-751, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 716-719, Vol. II, 2nd Ed.) and/or pages 16-7 to 16-9, Being a Nursing Aide, 1st Ed. (pp. 53-58, 2nd Ed.).

2. Attend lecture and demonstration by your instructor.

3. View, as available, the following filmstrips:

   a. "Handwashing" - Lippincott film loops
   b. "Asepsis - Medical and Surgical" - Lippincott film loops
   c. "Gown, Gloves, Mask - Single Use" - Lippincott film loops
   d. "Isolation Technique" - Trainex
   e. "Medical Asepsis" - Trainex #PC 376
   f. "Medical Asepsis - Special Needs Series" - Trainex #SN2

4. Using the Performance Checklist as a guide, practice the entire procedure with a classmate.

5. Identify steps in the procedure that seem especially difficult for you. Practice these and have your instructor offer suggestions.

6. Identify information that would be especially important to include in an explanation of isolation to the patient. Role play your explanation.

7. Complete the performance checksheet.

Name________________________
Date________________________

PERFORMANCE CHECK

Unit IV, Module B, Task 1

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Don gown, mask and gloves.		
a. Remove watch and rings.		
b. Wash hands.		
c. Remove mask from container; place over nose and mouth and tie securely, top strings first.		
d. Hold gown at neck and let unfold.		
e. Put arms through sleeves, one at a time, touching only inside of gown.		
f. Adjust gown.		
g. Tie neck tapes.		
h. Bring gown together and tie waist belt.		
i. Obtain glove wrapper; lay on flat surface and unfold.		
j. Remove powder and powder hands if appropriate.		
k. Remove one glove from holder by grasping folded edge and place on hand. Repeat for second glove.		
l. Adjust gloves over gown and on fingers		
2. Remove gown, mask and gloves.		
a. Untie waist belt of gown and pull toward front.		
b. Wash hands.		
c. Untie neck ties.		
d. Remove mask by untying bottom strings first		
e. Dispose of masks		
f. Pull sleeves off one at a time without touching outside of gown.		
g. Remove gown and dispose of it properly.		
h. Remove one glove at a time. (Do not touch skin with dirty surface.)		
i. Dispose of gloves.		
j. Wash hands before and after leaving unit.		

Student Competency Sheet

Unit VI: MEDICAL AND SURGICAL ASEPSIS

Module B: Medical Asepsis

Task 2: FOLLOW PROPER ISOLATION TECHNIQUES (SERVE AND REMOVE DIET TRAY)

Performance Checklist

1. To serve food trays: NOTE: Check agency policy for specifics.
   - a. Wash hands.
   - b. Check diet card and food tray.
   - c. Carry food tray to entrance of isolation unit.
   - d. Put on gown, gloves and mask, if applicable.
   - e. Prepare patient's food.
   - f. Serve patient's tray.
   - g. Remove gown, gloves and mask, if applicable.
2. To remove food tray:
   - a. Wash hands.
   - b. Put on gown, gloves and mask, if applicable.
   - c. Pour remaining liquids in designated area.
   - d. Place remaining solids in bag for disposal.
   - e. Remove dishes.
   - f. Remove gown, gloves and mask, if applicable.
   - g. Secure help to "double-bag" items removed from room.
   - h. Wash your hands.

Test

Items Needed:
1. Isolation unit
2. Patient
3. Agency policy
4. Food tray
5. Handwashing facilities
6. Two (2) gowns
7. Two (2) pairs of gloves
8. Two (2) masks
9. Disposal bags
10. Co-worker

Task:
1. Serve the food tray.
2. Remove the food tray.

Standard:
1. The food tray will be served and removed without contaminating yourself.
2. The food tray will be removed without contaminating the environment outside the isolation unit.

Learning Activities

1. Read page 751, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 722-723, Vol. II, 2nd Ed.) and/or pages 16-9 and 16-10, Being a Nursing Aide, 1st Ed. (pp. 50-51, 2nd Ed.) and/or Fundamental Skills in Patient Care, Lewis, pp. 462-464.
2. Observe a demonstration by your instructor.
3. Practice this task.
4. Identify, in small groups, the importance of esthetic conditions during mealtime and how these can best be maintained in the isolation unit. Summarize your group's conclusions and share them with your instructor and fellow students.
5. Perform a return demonstration for your instructor and have him/her critique your performance.

Student Competency Sheet

Unit VI: MEDICAL AND SURGICAL ASEPSIS

Module B: Medical Asepsis

Task 3: FOLLOW PROPER ISOLATION TECHNIQUES (DISPOSE OF SOILED MATERIAL)

Performance Checklist

1. Put on isolation gown, mask and gloves.
2. Gather soiled items and place into bag.
3. Tie the bag.
4. Place sealed bag into clean bag which second person (clean person) is holding outside unit.
5. Tie and label bag (clean person).
6. Dispose of bag at appropriate place (clean person).
7. Remove and dispose of gown, mask and gloves.
8. Wash hands before and after leaving unit.

Test

Items Needed:

1. Isolation unit
2. Isolation gown, mask and gloves
3. Soiled materials
4. Bag
5. A partner

Task: Your instructor will provide a situation for you to dispose of soiled materials from an isolation unit.

Standard The procedure must be completed without contamination.

Learning Activities

1. Read page 754, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 724-725, Vol. II, 2nd Ed.).

2. Attend lecture and demonstration on isolation techniques by your instructor.

3. Review filmstrip, "Medical Asepsis - Special Needs Series", Trainex SN2, or other filmstrips depicting such techniques.

4. Practice this task.

5. Have your instructor evaluate your performance in a simulated situation.

Student Competency Sheet

Unit VI: MEDICAL AND SURGICAL ASEPSIS

Module B: Medical Asepsis

Task 4: FOLLOW PROPER ISOLATION TECHNIQUES (TERMINAL DISINFECTION)

Performance Checklist

1. Put on gown (mask and gloves if indicated by agency).
2. Put all articles which can be autoclaved into one bag.
3. Place bag in clean bag held by clean person outside room.
4. Dispose of any disposable items.
5. Wipe delicate instruments, gown standard and other items which cannot be autoclaved with germicidal solution.
6. Give instruments to clean person using double bagging technique.
7. Label bag and send to central processing (clean person).
8. Remove all burnable articles using double bagging technique.
9. Label bag and send to incinerator (clean person).
10. Remove all unused items in same manner as above (steps 2, 3, 4 and 5), separating those which are to be autoclaved from those which cannot be autoclaved.
11. Place soiled linen in laundry bag.
12. Wash hands.
13. Remove gown and place in laundry bag.
14. Place laundry bag in clean bag held by clean person outside room.
15. Label bag and send to laundry.
16. Notify housekeeping that terminal cleaning is needed.

Test

Items Needed:
1. Vacant isolation unit
2. Germicidal solution
3. Basin
4. Bags
5. An assistant outside the room

Task: Your instructor will provide a situation for you to terminally disinfect an isolation unit.

Standard: The procedure must be performed without contamination.

Learning Activities

1. Read pages 756-758, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 727-729, Vol. II, 2nd Ed.).

2. Attend lecture and demonstration by your instructor on terminal disinfection.

3. Review the segments on terminal disinfection of any of the filmstrips available to you. (See list in Learning Activities - Task 1, of Module B - Medical Asepsis.)

4. In pairs or small groups, identify various germicides that may be used in this task. Note the safety precautions in using such solutions.

5. Practice this task in a simulated situation.

6. Have your instructor evaluate your performance in a simulated situation.

Student Competency Sheet

Unit VI: MEDICAL AND SURGICAL ASEPSIS

Module B: Medical Asepsis

Task 5: SET UP ISOLATION UNIT

Performance Checklist

1. Check physician's orders.
2. Wash hands.
3. Assemble equipment and supplies.
4. Identify area with ISOLATION sign.
5. Place equipment and supplies in unit.
6. Provide adequate explanations for patient and family involved.

Test

Items Needed:
1. Thermometer and holder.
2. Paper bags.
3. Toilet tissue.
4. Wipes.
5. Paper towel.
6. Wash basin.
7. Soap and holder.
8. Emesis basin.
9. Drinking water set up.
10. Toothbrush and tooth paste.
11. Bedpan and/or urinal
12. Personal items such as razor, toiletries, etc.
13. Waste basket with plastic liner.
14. Food tray with silverware.
15. Mattress and pillow with plastic covers.
16. Linens.
17. Standard for gown.
18. Additional storage facilities to hold gloves, masks and gowns.
19. Linen hamper.
20. Laundry bag with holder.
21. Plastic bags.
22. Special equipment as required for patient care.

Task: Set up a designated area as an isolation unit.

Standard:
1. The isolation unit must be set up for patient occupancy in accordance with agency policies.
2. Explanations must be provided and repeated as necessary for patient and family involved.

Learning Activities

1. Read pages 540-543, Total Patient Care, 4th Ed; pages 454-467, Fundamental Skills In Patient Care.

2. View the following filmstrips: "The Isolated Patient" - Career Aids; "Asepsis - Medical and Surigical" - Lippincott Film Loops; "Isolating Communicable Enteric and Respiratory Disease" - TRAINEX #427; "Isolation Technique" - TRAINEX; "Principles of Isolation Technique" - TRAINEX #404.
3. Identify the variety of equipment that may be used to isolate (1) a communicable respiratory disease, (2) a communicable enteric disease.
4. Attend a lecture/discussion session illustrating isolation "set-ups" in current use in your teaching hospital(s)/agencies.
5. Practice the task with such available equipment as may be required.
6. In small groups, outline points of explanation that would be particularly helpful for the patient and his family.
7. Have your instructor evaluate your performance of this task in a simulated situation and, as assigned, in the clinical setting.

Student Competency Sheet

Unit VI: MEDICAL AND SURGICAL ASEPSIS

Module B: Medical Asepsis

Task 6: COLLECT SPECIMEN FROM ISOLATED PATIENT

Performance Checklist

1. Check physician's orders.
2. Wash hands.
3. Assemble equipment and supplies.
4. Put on mask, gown and gloves, if applicable.
5. Identify patient and explain procedure.
6. Collect specimen.
7. Label specimen container.
8. Place specimen container in bag.
9. Provide for patient's comfort and safety.
10. Place bag containing specimen into clean bag held by co-worker outside isolation unit.
11. Label bag with isolation tags.
12. Remove gloves, gown, and mask, if applicable.
13. Transport specimen to laboratory.
14. Record appropriately.

Test

Items Needed:

1. Isolation unit
2. Patient
3. Physician's orders
4. Mask
5. Gown
6. Gloves
7. Bedpan or urinal
8. Specimen container
9. Bag
10. Isolation tag
11. Laboratory requisition
12. Cleaning materials
13. Co-worker

Task: With the assistance of a co-worker, collect a specimen from the isolated patient.

Standard:

1. The specimen must be in the proper container.
2. The container must be labeled with isolation tags.
3. Proper isolation technique must be maintained.

Learning Activities

1. Read:
   a. Pages 539-544, Total Patient Care, Johnston and Hood.
   b. Pages 716-724, Nursing Skills for Allied Health Services, Vol. II, 2nd Ed. (1st Ed., Vol. III, page 753).

2. Review filmstrips "Principles of Isolation Technique" - TRAINEX #404 and "Medical Asepsis" #PC 376.

3. Practice this task with a fellow student in the laboratory.

4. With a partner, identify (a) various specimens that might be collected and (b) special precautions that might be related to the mode of transfer for the suspected disease. Review your list with your instructor.

5. Have your instructor supervise your performance in the clinical setting.

6. Have your instructor evaluate your performance. Supervision must continue until all standards are met.

UNIT VII

CARING FOR THE TERMINAL PATIENT

Terminal Objectives

Upon completion of the module in this unit, you will:

- Use proper methods to assist with post-mortem care, including coping with anxiety of the family and yourself.

Student Competency Sheet

Unit VII: CARING FOR THE TERMINAL PATIENT

Module A: Caring For the Body After Death

Task 1: ASSIST WITH POST-MORTEM CARE

Performance Checklist

1. Notify appropriate personnel according to agency policy.
2. Assemble equipment and supplies.
3. Wash hands.
4. Provide for privacy.
5. Place body in supine position, closing eyes (by gently pulling on eyelashes) and mouth (check hospital policy regarding dentures).
6. Remove all valuables unless family desires otherwise. (If a ring is to be left on finger, secure it with adhesive tape.) Check institution policy.
7. Clean patient's body. (Check institution policy.)
8. Arrange hair.
9. Change dressing, if necessary.
10. Dress and identify the body, according to agency procedure.
11. Place large plastic sheet on gurney. Open sheet fully.
12. Place body on gurney.
13. Fold plastic sheet around body.
14. Cover body with clean sheet.
15. Care for all valuables removed and any other personal property of patient according to agency policy.
16. Record appropriately, being sure to state or record where valuables and clothing were sent.
17. Transport body to mortuary. Take shortest route to morgue. Close other patients' doors en route.

Test

Items Needed:

1. Expired patient
2. Copy of agency policy regarding post-mortem care
3. Wash cloth
4. Towel
5. Soap
6. Warm water in basin
7. Clean garments
8. Comb and brush
9. Shroud or post-mortem kit

Task: Prepare the body for the mortuary.

Standard

1. The body must be identified.
2. The body must be clean and neat.
3. Preparations must follow agency policy.
4. Privacy and respect for the patient and family must be maintained.

Learning Activities

1. Read pages 571-577, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (pp. 700-709, Vol. II, 2nd Ed.) and/or pages 17-6 to 17-9, Being a Nursing Aide, 1st Ed. (pp. 352-356, 2nd Ed.).

2. Attend a demonstration, in the learning lab, of applying a shroud or appropriate post-mortem sheets on the mannequin.

3. Practice the task and perform a return demonstration for fellow students or your instructor.

4. Watch the following filmstrips, in small discussion groups, if possible:

   a. "Death and Dying" - Trainex #3501
   b. "Care of the Patient Who Is Dying" - Trainex #403
   c. "Spiritual Needs of the Patient" - Segment on death - Trainex #155
   d. "Care of the Dying Patient - Signs and Aftercare" - Train-Aide

5. Discuss the significance of attentive nursing care for the body of the expired patient. What implications would this have for family members present?

6. Identify situations that might be anxiety-producing for the nurse, when caring for his/her first dying patient. Discuss these situations and various alternative behaviors with your instructor and others in your small discussion groups.

7. Identify new terms associated with terminal illness, death and post-mortem care.

8. Enter these terms in your vocabulary notebook and have your instructor check the definitions.

UNIT VIII

ADMINISTERING EMERGENCY TREATMENTS

Terminal Objectives

Upon completion of the modules in this unit, you will:

- Give artificial ventilation to an unconscious adult or infant.
- Give external cardiac compression to a patient with an unwitnessed cardiac arrest.
- Control an external hemorrhage.
- Insert an oropharyngeal (oral) airway.

Student Competency Sheet

Unit VIII: ADMINISTERING EMERGENCY TREATMENTS

Module A: Artificial Ventilation and Cardiac Compression

Task 1: GIVE ARTIFICIAL VENTILATION TO AN UNCONSCIOUS ADULT

Performance Checklist

1. Establish unresponsiveness and summon assistance.
2. Open airway.
   - a. Position patient on his/her back.
   - b. Tilt patient's head backward as far as possible.
   - c. Clear foreign matter from mouth and throat.
   - d. Place one hand beneath patient's neck and lift it.
   - e. Use other hand to press forehead backward.
3. Check for breathing.
   - a. Look for chest movement.
   - b. Listen for air movement at nose and mouth.
4. Ventilate patient.
   - a. Mouth-to-mouth ventilation.
     - (1) Tilt patient's head back.
     - (2) Pinch victim's nostrils closed with thumb and finger of hand used to press forehead down.
     - (3) Take a deep breath.
     - (4) Make an airtight seal over patient's mouth with your mouth.
     - (5) Exhale forcefully into patient's mouth.
     - (6) Remove mouth and allow patient to exhale passively.
   - b. Mouth-to-nose ventilation.
     - (1) Tilt patient's head with one hand on forehead and lift the patient's jaw with the other hand.
     - (2) Take a deep breath.
     - (3) Make air tight seal around patient's nose with your mouth.
     - (4) Exhale forcefully into patient's nose.
     - (5) Remove mouth and allow patient to exhale passively.
   - c. Mouth-to-stoma ventilation.
     - (1) Open your mouth widely.
     - (2) Take a deep breath.
     - (3) Make an airtight seal around the stoma with your mouth.
     - (4) Exhale forcefully into stoma.
     - (5) Remove mouth and allow patient to exhale passively.
5. Repeat cycle at rate of twelve (12) ventilations per minute.
6. Continue procedure until
   - a. Care is assumed by physician or
   - b. Patient is transferred to advanced life support unit.

NOTE: Repeat steps to ventilate the patient four (4) times initially.

Test

Items Needed:
1. Mannequins to simulate an unconscious adult.
2. Stoma.

Task:
1. Perform mouth-to-mouth artificial ventilation.
2. Perform mouth-to-nose artificial ventilation.
3. Perform mouth-to-stoma artificial ventilation.

Standard: Your performance will be evaluated by your instructor using a performance checksheet. All applicable checksheet items must be rated "acceptable."

Learning Activities

1. Read, as available, current CPR literature from American Heart Association or American Red Cross and/or Clinical Nursing Techniques, 3rd Ed., Dison, pages 339-353.

2. Watch, as available, filmstrips listed below:

   a. "Methods of Cardiopulmonary Resuscitation" - Trainex #329
   b. "Physiology of Respiration" - Trainex
   c. "CPR - Initial Phase" - Trainex

3. Participate in prescribed CPR course for appropriate certification.

4. Review any portions of available audio-visual resources to illustrate artificial ventilation.

5. Complete the performance checksheet.

Name______________________________
Date______________________________
Unit VIII, Module A, Task 1

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Recognized unconsciousness and summoned help.		
2. Established open airway.		
3. Established breathlessness.		
MOUTH-TO-MOUTH VENTILATION		
4. Tilted patient's head back.		
5. Pinched patient's nostrils closed with thumb and finger.		
6. Made airtight seal over patient's mouth with his/her mouth.		
7. Exhaled forcefully into patient's mouth.		
8. Removed mouth from patient's and allowed patient to exhale passively.		
9. Repeated cycle at rate of twelve (12) ventilations per minute.		
MOUTH-TO-NOSE VENTILATION		
10. Tilted patient's head back with one hand on the forehead and lifted the patient's lower jaw with the other hand.		
11. Made airtight seal over patient's nose.		
12. Exhaled forcefully into patient's nose.		
13. Removed mouth from patient's nose and allowed patient to exhale passively.		
14. Repeated cycle at rate of twelve (12) ventilations per minute.		

Name
Date
Unit VIII, Module A, Task 1

PERFORMANCE CHECK (Continued)

ACTIVITY	RATING	
	Acceptable	Unacceptable
MOUTH-TO-STOMA VENTILATION		
15. Opened mouth wide.		
16. Made airtight seal around stoma with mouth.		
17. Exhaled forcefully into stoma.		
18. Removed mouth from stoma and allowed patient to exhale passively.		
19. Repeated cycle at rate of twelve (12) ventilations per minute.		
20. Repeated steps to ventilate the patient four (4) times initially.		

Student Competency Sheet

Unit VIII: ADMINISTERING EMERGENCY TREATMENTS

Module A: Artificial Ventilation and Cardiac Compression

Task 2: GIVE ARTIFICIAL VENTILATION TO AN UNCONSCIOUS INFANT

Performance Checklist

1. Establish unresponsiveness and summon assistance.
2. Open airway.
3. Establish breathlessness.
4. Ventilate patient.
   a. Mouth-to-mouth/nose
      (1) Tilt head back.
      (2) Make an airtight seal over patient's mouth and nose with your mouth.
      (3) Puff cheeks with air.
      (4) Exhale air in cheeks to ventilate patient.
      (5) Remove mouth from patient's mouth/nose and allow to exhale passively.
   b. Mouth-to-stoma (probably cannot be demonstrated with mannequin)
      (1) Make an airtight seal around stoma with your mouth.
      (2) Puff cheeks with air.
      (3) Exhale air in cheeks to ventilate patient.
      (4) Remove mouth from stoma and allow patient to exhale passively.
5. Repeat cycle at rate of twenty (20) ventilations per minute.
6. Continue procedure until:
   a. Care is assumed by physician, or
   b. Patient is transferred to advanced life support unit.

NOTE: Repeat steps to ventilate the patient four (4) times initially.

Test

Items Needed:	Mannequin simulating an unconscious infant.
Task:	Perform mouth-to-mouth/nose artificial ventilation on an infant mannequin.
Standard:	The procedure will be evaluated by your instructor using a checksheet of performance. All items must be rated "acceptable."

Learning Activities

1. Read pages 349-350, Clinical Nursing Techniques, 3rd Ed., Dison.
2. Review illustrations pertinent to children and infants in audio-visual resources listed in Task 1 of this Module.
3. Complete performance checksheet.

Name ____________________
Date ____________________
Unit VIII, Module A, Task 2

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Established unresponsiveness and summoned help.		
2. Established open airway.		
3. Established breathlessness.		
MOUTH-TO-MOUTH/NOSE VENTILATION		
4. Tilted patient's head back.		
5. Made airtight seal over patient's mouth and nose with his/her mouth.		
6. Puffed cheek with air. Exhaled air in cheeks to ventilate patient.		
7. Removed mouth from patient's mouth/nose and allowed patient to exhale passively.		
8. Repeated cycle at rate of twenty (20) ventilations per minute.		
MOUTH-TO-STOMA VENTILATION		
9. Made an airtight seal around stoma with his/her mouth.		
10. Puffed cheeks with air.		
11. Exhaled air in cheeks to ventilate patient.		
12. Removed mouth from stoma and allowed patient to exhale passively.		
13. Repeated cycle at rate of twenty (20 to twenty-four (24) ventilations per minute.		
14. Repeated steps to ventilate patient four (4) times initially.		

Student Competency Sheet

Unit VIII: ADMINISTERING EMERGENCY TREATMENTS

Module A: Artificial Ventilation and Cardiac Compression

Task 3: GIVE EXTERNAL CARDIAC COMPRESSION TO A PATIENT WITH AN UNWITNESSED CARDIAC ARREST

Performance Checklist

1. Palpate for carotid pulse to establish pulselessness.
2. Perform external cardiac compression for adults.
   a. Place patient supine on the floor or ground. (If in bed, place a board under patient's back.)
   b. Locate lower half of sternum.
   c. Apply heel of one hand over lower half of sternum.
   d. Place other hand on top of first hand.
   e. Keep arms straight and elbows locked.
   f. Apply pressure so that sternum is depressed one and one-half to two (1-1/2 - 2) inches.
   g. Repeat cycle at rate of sixty to eighty (60-80) compressions per minute.
3. Perform external cardiac compression for infants/children.
   a. Palpate for carotid pulse to establish pulselessness.
   b. Place firm support under the patient's back.
   c. Apply compression to the mid-sternum of infants and small children.
      (1) Use heel of one hand to depress the sternum of children three-fourths and one and one-half (3/4-1-1/2) inches
      (2) Use the tips of the index and middle fingers to depress sternum of infants one-half to three-fourth (1/2 - 3/4) inches.
   d. Repeat cycle at rate of eighty to one hundred (80-100) times per minute.

CAUTION: 1. DO NOT DELIVER PRECORDIAL THUMP TO INFANTS OR CHILDREN. DELIVER PRECORDIAL THUMP ONLY ON WITNESSED CARDIAC ARRESTS WITHIN ONE MINUTE AFTER ARREST OCCURS.
2. Check current certification courses for any changes in CPR guidelines.

Test

Items Needed: 1. Mannequin simulating an adult patient.
2. Mannequin simulating an infant patient.

Task: Perform external cardiac compression to a patient with an unwitnessed cardiac arrest.

Standard: The procedure will be evaluated by your instructor using a performance checksheet. All items must be rated "acceptable."

Learning Activities

1. Read references listed in Task 1 of this Module.
2. Review audio-visual resources listed in Task 1 of this Module.
3. Participate in a prescribed certification course for CPR. Your instructor will provide required resources and prescribed hours of practice and instruction.
4. Complete the performance checksheet included with this task.

Name____________________
Date____________________
Unit VIII, Module A, Task 3

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
ADULT PROCEDURE		
1. Established pulselessness.		
2. Positioned patient correctly on hard surface.		
3. Located lower half of sternum.		
4. Positioned hands correctly.		
5. Positioned body correctly.		
6. Kept arms straight and elbows locked.		
7. Applied firm, heavy pressure to depress sternum 1-1/2 - 2".		
8. Repeated cycle at rate of eighty (80) compressions per minute. (NOTE: If two (2) persons are involved - rate is sixty (60) per minute.)		
INFANT/CHILD PROCEDURE		
9. Provided firm support under patient's back.		
10. Positioned hands/fingers correctly.		
11. Depressed sternum appropriately (1/2 - 3/4" for infants, 3/4 - 1-1/4" for children).		
12. Repeated cycle at rate of eighty to one hundred (80-100) depressions per minute.		

Student Competency Sheet

Unit VIII: ADMINISTERING EMERGENCY TREATMENTS

Module A: Artificial Ventilation and Cardiac Compression

Task 4: INSERT ORAL AIRWAY

Performance Checklist

1. Place patient on back.
2. Lift chin and tilt head backwards as far as possible.
3. Open mouth so tube can be inserted.
4. Clear foreign matter from mouth and throat.
5. Slide tube through teeth and over the tongue until flange touches lips.
6. Record procedure.

Test

Items Needed: 1. Mannequin simulating an unconscious patient
2. Oropharyngeal airway

Task: Insert an oropharyngeal airway in the mannequin.

Standard: Insert the oropharyngeal airway until the flange touches the lips.

Learning Activities

1. Read page 347, Clinical Nursing Techniques, 4th Ed. and/or pages 487-488, Nursing Skills For Allied Health Services, Vol. II, 1st Ed.

2. View filmstrips:
    a. "Respiratory Emergencies" - Career Aids
    b. "Cardiopulmonary Resuscitation - Initial Phase" - TRAINEX #186.

3. Observe a demonstration by your instructor in the laboratory.

4. With a partner, practice this task on the mannequin. Evaluate each others' performance.

5. Have your instructor evaluate your performance in a simulated situation.

6. Identify patient care situations that might require the use of an oral airway. Supplement a small group or large group discussion of these situations with a visit to emergency department(s) of your teaching hospital(s).

Student Competency Sheet

Unit VIII: ADMINISTERING EMERGENCY TREATMENTS

Module B: Hemorrhage Control

Task 1: CONTROL EXTERNAL HEMORRHAGE

Performance Checklist

1. Determine type of bleeding (arterial, venous, capillary).
2. Control bleeding by applying:
    a. Direct pressure over wound.
    b. Pressure dressing.
    c. Pressure over appropriate pressure point.
    d. Tourniquet (as last resort only).
3. Dress wound.
4. Treat for shock:
    a. Position patient (elevate the lower extremities unless contraindicated).
    b. Assure adequate breathing.
    c. Avoid rough handling.
    d. Provide warmth (monitor vital signs, if possible).
    e. Give nothing by mouth.
5. Provide for patient's comfort.
6. Record appropriately.

Test

Items Needed:
1. Patient with simulated severe external bleeding.
2. Dressing
3. Tourniquet
4. Blankets
5. Pillow(s)
6. Equipment to monitor vital signs

Task:
1. Control the external hemorrhage.
2. Treat the patient for shock.

Standard:
The bleeding must be controlled.
Shock must be identified and treated.

Learning Activities

1. Read pages 723-724, Nursing Skills for Allied Health Services, Vol. II, 1st Ed. (p. 498, Vol. II, 2nd Ed.) and/or pages 353-359, Clinical Nursing Techniques, 3rd Ed., Dison.

2. On a diagram of the body, identify the main pressure points used in initial control of hemorrhage.

3. Outline the steps and corresponding precautions in the use of a tourniquet to control hemorrhage of an extremity.

4. Watch filmstrip, "Shock and Hemorrhage", by Trainex.

5. Select, at random, two situations where hemorrhage control is required. (Simulated situations will be described and provided by your instructor.)

6. Practice your responses with a fellow student.

7. Identify the cardinal symptoms of shock.

8. Outline the first-aid treatment for shock.

9. Using the Performance Checklist as a guide, complete the treatment for hemorrhage in a situation provided by your instructor.

10. Have your instructor evaluate your performance. Note his/her suggestions. Repeat such performances until the standards for this task have been met.

11. Identify new vocabulary used in the discussion of hemorrhage and shock.

12. Enter these terms in your vocabulary notebook.

UNIT IX

ESTABLISHING STERILE AREAS

Terminal Objectives

Upon completion of modules in this unit, you will:

- Open sterile packs without contaminating the wrapper or contents.
- Use sterile techniques to handle sterile equipment and supplies.
- Pour sterile solutions into a sterile container without contaminating the solution.
- Maintain sterile techniques while setting up a sterile field.

Student Competency Sheet

Unit IX: ESTABLISHING STERILE AREAS

Module A: Handle Sterile Equipment and Supplies

Task 1: OPEN STERILE PACKS

Performance Checklist

1. Check expiration date on pack.
2. Place pack in area where it is to be used.
3. Loosen wrapper tape.
4. Open distal flap first)
5. Open left flap)
6. Open right flap) CAUTION: Never reach across sterile field.
7. Open proximal flap)

NOTE: If pack has a double wrapper, the inner wrapper may be moved, with sterile gloves, to the sterile field and opened in the same manner.

8. Dispose of equipment.

Test

Items Needed: 1. Sterile pack
2. Sterile gloves or forceps, as required

Task: Open the sterile pack.

Standard: The sterile pack must be opened without contaminating the wrapper or contents.

Learning Activities

1. Read pages 46-54, Total Patient Care, Johnson and Hood, and/or pages 294-299, Fundamental Skills in Patient Care.

2. View filmstrip "Sterile Technique and Dressing Change" - TRAINEX.

3. Observe a demonstration by your instructor illustrating the various types of sterile packs used.

4. Practice opening sterile gloves and sterile packs.

5. Have your instructor evaluate your performance in the laboratory and the clinical setting.

Student Competency Sheet

Unit IX: ESTABLISHING STERILE AREAS

Module A: Handle Sterile Equipment and Supplies

Task 2: HANDLE STERILE EQUIPMENT AND SUPPLIES

Performance Checklist

1. Assemble equipment/packs.
2. Wash hands.
3. Open sterile pack.
4. Handle sterile items using forceps or sterile gloves.
5. Forceps technique
   a. Lift forceps from container vertically.
      (1) Keep forceps tips pointed downward.
      (2) Touch forceps handle only.
   b. Grasp sterile item with forceps.
      (1) Lift sterile item straight up. Do not drag.
      (2) Do not touch sterile area with forceps handle.
   c. Transfer sterile item to sterile field.
      (1) Transfer all items before replacing forceps in container.
6. Glove technique:
   a. Put on sterile gloves.
   b. Transfer sterile items by hand.
7. Dispose of equipment.

Test

Items Needed:
1. Pack of sterile equipment and supplies
2. Forceps
3. Sterile gloves
4. Waste receptacle

Task: Use sterile technique to handle the sterile equipment or supplies.

Standard: The sterile equipment and supplies must be handled without contaminating them.

Learning Activities

1. Read pages 46-54, Total Patient Care, Johnson and Hood, and pages 294-299, Fundamental Skills In Patient Care.

2. Attend a demonstration of this task using sterile gloves and forceps technique.

3. View filmstrip "Sterile Technique and Dressing Change" - TRAINEX.

4. Discuss the term "sterile field" with a fellow student. Add this term to your vocabulary notebook. Check your definition with your instructor.

5. Have your instructor evaluate your performance of this task in the laboratory, using a variety of sterile supplies.

6. Have your instructor evaluate your ability to don (put on) sterile gloves without contamination.

7. Have your instructor evaluate your ability to use sterile forceps as a means to transfer sterile items.

8. Perform this task, with your instructor's supervision, in the clinical setting, until the standard is consistently met.

Student Competency Sheet

Unit IX: ESTABLISHING STERILE ENVIRONMENT

Module A: Handle Sterile Equipment and Supplies

Task 3: POUR STERILE SOLUTIONS

Performance Checklist

1. Check label for correct solution.
2. Remove cap from bottle touching only outside of the cap.
3. Place cap upside down on table.
4. Unwrap sterile container and place on table.
5. Pour small amount of sterile solution into a waste recepticle.
6. Pour sterile solution into sterile container from a height of about 6".
7. Place cap on bottle of sterile solution. (Touch only outside of cap.)
8. Return bottle of sterile solution to proper storage.

Test

Items Needed:
1. Table
2. Bottle of sterile solution
3. Sterile container

Task: Pour the sterile solution from the bottle into the sterile container.

Standard: The pouring must be accomplished without contaminating the solution or the container.

Learning Activities

1. Read pages 46-54, Total Patient Care and page 297, Fundamental Skills In Patient Care.

2. View filmstrip "Sterile Technique and Dressing Change" - TRAINEX.

3. With a fellow student, practice this task in the laboratory. Evaluate each other's performance, based upon the performance checklist.

4. Have your instructor evaluate your performance in a simulated patient care situation.

Student Competency Sheet

Unit IX: ESTABLISHING STERILE AREAS

Module B: Establish Sterile Field

Task 1: SET UP STERILE FIELD

Performance Checklist

1. Wash hands.
2. Assemble equipment and supplies.
3. Place sterile pack near area where it is to be used.
4. Open sterile pack.
5. Using sterile gloves or forceps, remove drapes from pack.
6. Position drapes to establish sterile field.
7. Dispose of equipment and tidy area.

Test

Items Needed:
1. Your instructor will provide the necessary supplies.
2. Sterile pack
3. Sterile gloves
4. Forceps

Task: Set up a sterile field.

Standard: The sterile technique will not be broken as you set up a sterile field.

Learning Activities

1. Read pages 46-54, Total Patient Care and pages 294-295, Fundamental Skills In Patient Care.

2. Read Information Sheet IX-B-1 (Sterile Technique).

3. View filmstrip "Sterile Technique and Dressing Change" - TRAINEX.

4. Explain to your instructor the principles involved in maintaining a sterile field.

5. Review the definition of "sterile field" in your vocabulary notebook.

6. Add the following terms to your vocabulary notebook - don; transfer forceps; sterile technique.

7. Add other new terms associated with surgical asepsis to your vocabulary notebook. Check all definitions with your instructor.

8. Practice establishing a sterile field with the equipment available in the laboratory.

9. Have your instructor evaluate your performance (a) in a simulated situation and (b) in an actual patient care situation.

INFORMATION SHEET
IX-B-1

Aseptic Technique

I. GENERAL ACTIONS

Sterile objects must only come in contact with something sterile.

Clean objects must come into contact with clean objects.

If in doubt about the sterility of anything, consider it non-sterile (for ex: non-sterile person brushes close to sterile table and vice versa).

Never reach over a sterile field or object.

Never walk away from or turn your back on a sterile field.

Avoid talking, coughing, or sneezing over a sterile field.

Avoid spilling any solution on a sterile cloth or setup.

Keep sterile objects above waist level.

Articles transferred from one sterile area to another must be dropped from high.

Liquids must be poured from high, being sure not to touch the container rims.

Bare hands should never come in contact with sterile objects. Sterile gloves or sterile handling forceps must be used.

Sterile towels used for covering sterile trays should only be held by the outside edges.

Container lids are placed on the table with their inside surface facing up.

Peel back the cover of a solution flask or test tube, so that the edge of the cover never touches the lip.

The edges of the sterile field are considered contaminated.

II. STERILE FORCEPS TECHNIQUE

In removing sterile forceps from their container, never touch the inside of the container above the level of the solution with forceps tips.

Never tap the forceps on the top rim of the container.

II. STERILE FORCEPS TECHNIQUE (Continued)

When using or holding forceps, keep the tips horizontal to the handle or below it.

Carry the forceps high and in sight.

Make certain that the disinfectant solution from the forceps tips does not drip on the sterile field.

Sterile supplies are removed from their containers with sterile forceps.

III. OPENING STERILE PACKAGES

When opening sterile supplies, they must be opened in such a way that your fingers do not touch the inside of the wrapper or the sterile article.

Open sterile packages so that the edges of the wrapper are directed away from the worker.

The sterile package should be held or placed so that the last flap is opened toward the worker.

IV. CHANGING THE STERILE DRESSING

Sterile dressings should be replaced or reinforced if they are oozing or draining.

Always wash your hands before starting the dressing.

Supplies removed from the dressing cart that must be returned to that cart should be placed on a clean paper towel and handled with only clean hands.

Dressings should be lifted vertically from the wound and not dragged across them.

The outside layer of the dressing may be removed with clean hands by handling only the edges and corners.

The inside layers of the dressing must always be removed with sterile pick-ups.

Cleaning the wound should be done from clean to contaminated.

UNIT X

PREPARING PATIENTS FOR EXAMINATIONS OR SURGERY

Terminal Objectives

Upon completion of modules in this unit, you will:

- Assemble equipment, obtain and record vital signs, height and weight, position a patient, and assist with a physical examination.
- Prepare a patient and assist with rectal, vaginal and proctoscopic examinations.
- Give pre-operative skin care.
- Prepare a patient for surgery.

Student Competency Sheet

Unit X: PREPARING PATIENTS FOR EXAMINATIONS OR SURGERY

Module A: Physical Examinations

Task 1: ASSIST WITH PHYSICAL EXAMINATIONS

Performance Checklist

1. Wash hands.
2. Assemble equipment and supplies.
3. Explain procedure.
4. Obtain and record:
    a. Vital signs
    b. Height and weight, if applicable.
5. Escort patient to treatment room, if applicable.
6. Position and drape patient.
7. Assist physician.
8. Position patient for vaginal/rectal examination, if applicable.
9. Assist physician with vaginal/rectal examination, if applicable.
10. Escort patient back to room, if applicable.
11. Provide for patient's comfort.
12. Dispose of equipment and tidy area.
13. Report and record appropriately.

Test

Items Needed:

1. Patient
2. Sheets
3. Physician's orders
4. Stethoscope
5. Sphygmomanometer
6. Patient's record
7. Pen

Task:

1. Assemble necessary equipment.
2. Obtain and record vital signs and height and weight.
3. Position the patient.
4. Assist the patient and the physician throughout the examination.

Standard:

1. The patient must be positioned and draped in a manner to avoid unnecessary exposure of the patient's body.
2. The patient's comfort must be periodically assessed.

Learning Activities

1. Read pages 140-157, Fundamental Skills In Patient Care and/or pages 258-282, Nursing Skills For Allied Health Services, Vol. I, 2nd Ed. (1st Ed., Vol II, pages 523-545).

2. Attend a demonstration of this task in the laboratory.

3. Role play a patient care situation of assisting with a physical examination. Participate as (a) the patient, (b) the physician, (3) nurse.

4. Following your participation as the patient in these simulations:
   a. Write your impressions of the patient's feelings prior to, during, and following a physical examination.
   b. Expand your descriptions to include how you may have felt awaiting an examination in a physician's office or in the hospital.
   c. Share these descriptions in small groups.

5. In small groups, present a role play of this task for your instructor.* Have your instructor evaluate your performance and make note of suggestions.
   (* Include a thorough explanation for the patient.)

Student Competency Sheet

Unit X: PREPARING PATIENTS FOR EXAMINATIONS OR SURGERY

Module A: Physical Examinations

Task 2: PREPARE PATIENT FOR AND/OR ASSIST WITH RECTAL, VAGINAL, OR PROCTOSCOPIC EXAMINATIONS

Performance Checklist

1. Check physician's orders.
2. Wash hands.
3. Assemble equipment and supplies for the designated examination.
4. Identify patient and explain procedure.
5. Ask patient to void.
6. Transfer patient to treatment room, if applicable.
7. Position and drape patient.
   a. Rectal examination - Knee-chest position.
   b. Vaginal examination - Dorsal Lithotomy position.
   c. Proctoscopic examination - Knee-chest position.
8. Assist physician, as necessary.
9. Label specimens, if indicated.
10. Send specimens to laboratory, if indicated.
11. Assist patient to return to bed.
12. Provide for patient's comfort.
13. Tidy area.
14. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Sheet(s)
4. Specimen container
5. Labels

Task:
1. Assemble the equipment for each of the following examinations.
2. Prepare patient for and/or assist with rectal examination.
3. Prepare patient for and/or assist with vaginal examination.
4. Prepare patient for and/or assist with proctoscopic examination.

Standard:
1. The assembled equipment must be appropriate for the designated examination.
2. The patient positioning must be appropriate to the designated examination.

Learning Activities

1. Read:
    a. Pages 147-149, 154-155, Fundamental Skills In Patient Care.
    b. Page 266, Clinical Nursing Techniques, 4th Ed.
    c. Pages 49-54, Nursing Skills For Allied Health Services, Wood and Rambo, Vol. I, 2nd Ed. (1st Ed., Vol. I, pages 41-47)

2. Discuss, in small groups, ways the patient may be made more comfortable during and after such examinations. Compose a list of these suggestions and compare these with other groups.

3. Observe a demonstration by your instructor.

4. Practice this task in the laboratory setting, using the mannequin.

5. Identify information that should be included in an explanation to the patient before each of these examinations.

6. Role play an explanation of positions, equipment, etc., for each of the examinations listed.

7. Locate explanation sheets and/or consent forms used for the proctoscopic exam in your teaching hospital(s). Discuss their use and the possible responses of patients.

8. Have your instructor evaluate your performance in a simulated situation and in an actual patient care situation.

Student Competency Sheet

Unit X: PREPARING PATIENTS FOR EXAMINATIONS OR SURGERY

Module B: Surgical Preparation

Task 1: GIVE PRE-OPERATIVE SKIN CARE

Performance Checklist

1. Assemble equipment and supplies.
2. Identify patient and explain procedure.
3. Wash hands.
4. Provide for patient's privacy.
5. Drape patient.
6. Apply prep solution and scrub area.
7. Shave area.
8. Rinse well.
9. Dry area.
10. Provide for patient's comfort.
11. Tidy area.
12. Record procedure.

Test

Items Needed:
1. Patient scheduled for surgery
2. Prep solution
3. Safety razor
4. Basin of warm water
5. Towel

Task: Give the patient pre-operative skin care.

Standard:
1. The required prep solution must be used.
2. The prep site must be shaved free of hair without causing irritation or injury to the skin.

Learning Activities

1. Read pages 112-113, Total Patient Care, and/or pages 467-480, Nursing Skills For Allied Health Services, Vol. II, 2nd Ed. (1st Ed. Vol. II, pages 687-697).

2. View filmstrip "Pre-operative Skin Preparation" - TRAINEX #179.

3. Observe a demonstration of this task by your instructor.

4. Practice pre-operative skin care on a "pre-operative patient," using the laboratory mannequin.

5. List special precautions that might be necessary when preparing various body surfaces for surgery; such as, scalp, perineum, face, hand. Review your list with your instructor.

6. Have your instructor evaluate your performance in a simulated situation.

7. Practice pre-operative skin care, with supervision, on pre-operative patients as assigned by your instructor.

8. Have your instructor evaluate your performance in these actual patient care situations.

Student Competency Sheet

Unit X: PREPARING PATIENT PATIENTS FOR EXAMINATIONS AND SURGERY

Module B: Surgical Preparation

Task 2: PREPARE PATIENT FOR SURGERY

Performance Checklist

1. Check physician's orders.
2. Wash hands.
3. Identify patient and explain preparations.
4. Take and record vital signs.
5. Provide AM care.
6. Assist patient to put on hospital gown and/or other garments, as needed.
7. Tidy the bed.
8. Remove jewelry, dentures, partial plates, nail polish, make-up, artificial body parts, as indicated.
9. Secure patient's valuables.
10. Have patient void. (Catheterize, if applicable.)
11. Administer pre-operative medications at designated time.
12. Employ all safety measures.
13. Complete and sign surgery checklist.
14. Assist patient to stretcher.
15. Direct patient's family to appropriate waiting area and explain information they will receive there.
16. Record procedure.

Test

Items Needed:
1. Pre-operative patient
2. Physician's orders
3. Pre-operative checklist
4. Equipment and supplies to correspond to the checklist.

Task: Prepare the patient for surgery.

Standard:
1. All applicable items on the pre-operative checklist must be accomplished.
2. Explanations to patient and family must be accurate and appropriate to provide reassurance.

Learning Activities

1. Read:
   a. Pages 467-476, Nursing Skills For Allied Health Services, Vol. II, 2nd Ed. (1st Ed., Vol. II, pages 687-700).
   b. Pages 142-146, Total Patient Care, 4th Ed.
   c. Pages 432-454, Fundamental Skills In Patient Care.

2. View filmstrip "Preparing For Your Operation" - Train-aide Corporation.

3. In small groups, discuss how this filmstrip might be used to help prepare patients for surgery. Review portions of the filmstrip and make notes to assist you in performing this task.

4. View "Pre-operative and Post-operative Care" - TRAINEX #PC402.

5. Role play a patient care situation of pre-operative preparation. Have your instructor evaluate your performance in the laboratory and in the clinical setting.

6. Observe pre-operative preparation in the hospital setting.

7. As assigned by your instructor:
    a. Interview a patient (and his/her family) who has recently had surgery.
    b. Determine how pre-operative instruction was helpful to these individuals.
    c. Record your interviews and share these in small groups.

UNIT XI

ADMINISTERING MEDICATION

Terminal Objectives

Upon completion of modules in this unit, you will:

- Set up and administer oral medication.
- Administer parenteral medication by subcutaneous injection, by intradermal injection, by intramuscular injection, and by z-track technique.
- Follow proper procedure for recording medications administered.

Student Competency Sheet

Unit XI: ADMINISTERING MEDICATION

Module A: Oral Medication

Task 1: ADMINISTER ORAL MEDICATION

Performance Checklist

1. Compare physician's orders with patient's medication record.
2. Wash hands.
3. Assemble equipment and supplies.
4. Select proper medication and check label:
   a. As medication is taken from shelf.
   b. As medication is poured or counted.
   c. As medication is returned to shelf.
5. Compare medication label with patient's medication record.
6. Calculate dosage as necessary.
7. Pour medication.
8. Place medication and medicine card together on medication tray, if applicable.
9. Close medication container and return to storage, if applicable.
10. Take medication to bedside.
11. Greet patient and verify patient's identification by checking name band.
12. Hand medication to patient.
13. Give water to drink with medication, if applicable.
14. Observe patient until medication is swallowed.
15. Provide for patient's comfort.
16. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Oral medications
4. Patient's medication record
5. Medicine card
6. Medication tray
7. Medication cup, if applicable

Task:
1. Set up and administer oral medication.
2. Record medication administered.

Standard:
1. Patient and medication must be accurately identified and prepared.
2. Observe patient until medication is swallowed.
3. Medication must be properly recorded.

Learning Activities

1. Read:
    a. Pages 49-64, Practical Nursing Study Guide and Review, Von Gremp and Broadwell.
    b. Pages 70-75, Pharmacology For Practical Nurses, 4th Ed., Asperheim.
    c. Pages 331-335, Fundamental Skills In Patient Care.
    d. Page 40, Pediatrics For Practical Nurses, Thompson, 3rd Ed.
    e. Pages 127-129, Clinical Nursing Techniques, 4th Ed.

2. View:
    a. Filmstrip "Oral Medications" - Train-aide Corporation.
    b. Filmloop "Oral Medication" - Lippincott.

3. Identify the "5 rights" in medication administration.

4. a. Review abbreviations commonly used in the administration of oral medication.
    b. Enter new terms on units of measure in your vocabulary notebook.
    c. Check all definitions with your instructor.

5. Role play the entire procedure for administering oral medications. Work with a fellow student and check your performance with the performance checklist.

6. Have your instructor evaluate your performance. Note suggestions on the performance checklist.

7. As assigned by your instructor, perform the task in the clinical setting.

Student Competency Sheet

Unit XI: ADMINISTERING MEDICATION

Module B: Parenteral Medication

Task 1: ADMINISTER PARENTERAL MEDICATION

Performance Checklist

1. Compare physician's orders with patient's medication records.
2. Wash hands.
3. Assemble equipment and supplies.
4. Select proper medication and check label as medication is:
   a. Removed from storage area.
   b. Drawn into syringe.
   c. Replaced to storage or container is discarded.
5. Compare label and patient's medication record.
6. Calculate correct dosage.
7. Prepare syringe.
8. Draw up proper dosage using sterile technique.
9. Expel air from syringe.
10. Return container to storage or discard, as appropriate.
11. Place medication and medicine card together on medicine tray, if applicable.
12. Take medication to patient's bedside.
13. Greet patient and verify patient's identification by checking name band.
14. Identify and prepare injection site.
15. Expel air from syringe.
16. Administer medication in one of the following ways:
    a. Subcutaneously:
       (1) Hold syringe between thumb and index finger.
       (2) Insert needle at 45° angle.
       (3) Asperate plunger.
       (4) Inject medication.
       (5) Remove needle and massage area.
    b. Intradermally:
       (1) Support patient's arm with anterior portion upward. Hold skin on forearm tight.
       (2) Hold syringe with bevel of needle facing upward.
       (3) Insert needle at 10°-15° angle (almost parallel to skin) so that only bevel of needle penetrates the skin.
       (4) Inject medication slowly so that white wheal appears.
       (5) Withdraw needle.
       (6) Wipe gently with no pressure.

XI-B-1 Performance Checklist (Continued)

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c. Intramuscularly:
   (1) Hold syringe between thumb and index finger.
   (2) Insert needle at 90° angle.
   (3) Asperate plunger.
   (4) Inject medication.
   (5) Remove needle and massage area.
d. Z-track technique:
   (1) Draw 1/2 cc of air into syringe.
   (2) Retract skin laterally in gluteal area.
   (3) Insert needle at 90° angle using at least a 2 inch needle.
   (4) Asperate plunger.
   (5) Inject medication and wait 10 seconds.
   (6) Remove needle.
   (7) Release skin. DO NOT MASSAGE AREA WHEN USING Z-TRACK TECHNIQUE.

17. Apply bandaid, if necessary.
18. Provide for patient's comfort.
19. Remove and dispose of equipment properly.
20. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Parenteral Medications
4. Patient's medication records
5. Syringe
6. Medicine card
7. Medicine tray
8. Alcohol sponge

Task:
1. Administer parenteral medications subcutaneously, intradermally, intramuscularly and by z-track.
2. Record medication administered.

Standard:
1. The procedures will be evaluated by your instructor using a checksheet of performance.
2. All items must be rated "acceptable."

Learning Activities

1. Review pages 49-64, Practical Nursing Study Guide and Review, Von Gremp and Broadwell.

2. Read:
   a. Pages 70-75, Pharmacology for Practical Nurses, Asperheim.
   b. Pages 138-158, Clinical Nursing Techniques, 4th Ed.
   c. Pages 332, 336-339, Fundamental Skills in Patient Care.

3. View:
    a. Filmstrip "Parenteral Medications" - Train-aide Corporation.
    b. Filmstrip "Intramuscular and Subcutaneous Injections" - TRAINEX #434.
    c. Filmloop "Parenteral Medications" - Lippincott filmloops.

4. Explain the "5 rights" in medication administration.

5. List and explain the commonly used abbreviations that apply to the preparation and administration of parenteral medications.

6. Observe a demonstration by your instructor of each of the parenteral modes listed in this task.

7. Practice each of the parenteral modes using the laboratory mannequins or other equipment provided in the laboratory.

8. Practice each of the parenteral modes with fellow students, as assigned by your instructor. If appropriate and permitted by your learning institution, participate as both a patient and a nurse.

9. Complete the performance checklist in a simulated patient care situation.

10. Complete the performance checklist for your instructor:
    a. in a simulated situation.
    b. in an actual patient-care situation.

Name____________________
Date____________________
Unit XI, Module B, Task 1

PERFORMANCE CHECKSHEET

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Identified medicine, dosage, time and route of administration.		
2. Washed hands.		
CHECKED MEDICATION LABEL		
3. When medication was removed from storage.		
4. As medication was drawn into syringe.		
5. As medication was replaced to storage or container discarded.		
PREPARED MEDICATION FOR INJECTION		
6. Calculated correct dosage.		
7. Prepared syringe without contamination.		
8. Placed medication and medicine card together on medicine tray.		
PREPARED PATIENT FOR MEDICATION		
9. Greeted patient and verified patient's identification.		
10. Prepared injection site.		
11. Expelled air from syringe.		
GAVE SUBCUTANEOUS INJECTIONS		
12. Inserted needle at 45° angle.		

PERFORMANCE CHECKSHEET (Continued)

ACTIVITY	RATING	
	Acceptable	Unacceptable
13. Asperated plunger before injecting medication.		
14. Removed needle and massaged area.		
GAVE INTRADERMAL INJECTION		
15. Held skin on forearm tight.		
16. Inserted needle at 10°-15° angle with bevel of needle upward.		
17. Injected medication slowly until white wheal appeared.		
18. Withdrew needle and wiped area gently with no pressure.		
GAVE INTRAMUSCULAR INJECTION		
19. Injected needle quickly and firmly at 90° angle.		
20. Asperated plunger before injecting medication.		
21. Removed needle and massaged area.		
GAVE INJECTION USING Z-TRACK TECHNIQUE		
22. Retracted skin laterally.		
23. Inserted needle at 90° angle.		
24. Asperated plunger.		
25. Injected medication and waited 10 seconds.		
26. Removed needle and released skin without massaging area.		

PERFORMANCE CHECKSHEET (Continued)

ACTIVITY	RATING	
	Acceptable	Unacceptable
COMPLETED PROCEDURE		
27. Applied bandaid, if necessary.		
28. Removed and disposed of equipment.		
29. Recorded procedure.		

UNIT XII

CARING FOR THE RESPIRATORY TRACT

Terminal Objectives

Upon completion of modules in this unit, you will:

- Safely administer oxygen to a patient according to prescribed method and liter flow.
- Suction a patient's nasal passage and throat to free the passage of mucus without injury to mucous membranes.

Student Competency Sheet

Unit XII: CARING FOR THE RESPIRATORY TRACT

Module A: Respiration Aids

Task 1: ADMINISTER OXYGEN

Performance Checklist

1. Check physician's orders.
2. Obtain equipment and supplies.
3. Wash hands.
4. Identify patient and explain procedure.
5. Place "No Smoking" sign on door and instruct all persons present.
6. Connect humidifier and flowmeter to oxygen outlet.
7. Connect tubing from humidifier bottle to reach patient.
8. Attach connector tubing to cannula, mask, catheter, or tent.
9. Adjust oxygen flow as prescribed. Always adjust before administration.
10. Fit and adjust cannula, mask, catheter, or tent to/over patient.
11. Record procedure.

NOTE: When using cylinder oxygen, the tank should be "cracked" before it is carried to the patient's room.

Test

Items Needed:
1. Patient
2. Physician's orders
3. "No Smoking" sign
4. Humidifier
5. Flowmeter
6. Tubing
7. Cannula, mask, catheter or tent
8. Oxygen cylinder

Task: Administer oxygen to the patient using the method and liter flow prescribed.

Standard:
1. The oxygen liter flow and method of administration must be as designated by the physician's orders.
2. All safety measures must be consistently applied.

Learning Activities

1. Read pages 82-94, Clinical Nursing Techniques, 3rd Ed. and/or pages 202-205, Total Patient Care, 4th Ed. and/or pages 402-410, Fundamental Skills In Patient Care.

2. Enter the following terms in your vocabulary notebook: anoxia, flowmeter, humidifier, cannula, I.P.P.B. (Intermittent Positive Pressure Breathing), inhalation. Check all definitions with readings or your instructor.

3. View "Oxygen Administration" - TRAINEX Pc 142. Pay particular attention to the equipment used.

4. Attend a lecture/demonstration session illustrating the use of portable oxygen as well as wall oxygen in your teaching hospital(s)/agencies.

5. Visit the Respiratory (Inhalation) Therapy Department of your teaching hospital(s) to view modes of oxygen administration.

6. Practice the preparation for and the administration of oxygen therapy.

7. List, in small or large groups, the safeguards necessary when oxygen is administered.

8. Have your instructor evaluate your performance of this task using the Performance Checklist and the standards stated.

9. As assigned by your instructor, assist with or administer the oxygen therapy as prescribed. Have your instructor evaluate your reporting and recording of this procedure, the patient's tolerance, and other pertinent observations.

Student Competency Sheet

Unit XII: CARING FOR THE RESPIRATORY TRACT

Module A: Respiration Aids

Task 2: SUCTION PATIENT'S UPPER RESPIRATORY PASSAGE

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Position patient.
5. Wash hands.
6. Turn on suction machine.
7. To suction nasal passage:
   a. Moisten catheter tip and insert catheter into nostril.
   b. Close suction valve.
   c. Suction approximately 15 seconds.
   d. Release suction valve.
   e. Remove and rinse catheter. Repeat process, if necessary.
   f. Repeat process for second nostril.
8. To suction throat:
   a. Moisten catheter tip and insert catheter into throat.
   b. Repeat steps 7b through 7e.
   c. Give mouth care.
9. Provide for patient's comfort.
10. Tidy area.
11. Record procedure, patient's tolerance, and pertinent observations.

Test

Items Needed: 1. Patient
2. Physician's orders
3. Suction machine

Task: Suction the patient's nasal passage and/or throat.

Standard: 1. The passage(s) must be free of mucus upon completion of the procedure.
2. The mucous membranes must not be injured.
3. All checksheet items must be rated acceptable.

Learning Activities

1. Read pages 195-198, Total Patient Care; page 452, Fundamental Skills In Patient Care, 4th Ed.

2. View, as available, "The Human Respiratory System" - Bell & Howell Filmstrips. Review the anatomy of the upper respiratory tract.

3. Identify the following structures on a diagram or anatomical figure provided by your instructor: nostril, uvula, nasopharynx, soft palate, hard palate, esophagus, trachea, larynx, nares.
4. Enter new terms in the list above in your vocabulary notebook. Check all definitions with your instructor.
5. Observe a demonstration of this procedure by your instructor.
6. Practice the task in the laboratory, using a mannequin.
7. Discuss, in small groups, as directed by your instructor, the safeguards applied to protect the delicate mucous membranes of the respiratory tract.
8. Summarize and list the safeguards identified in your discussion group.
9. Report discussion topics to the larger group; add safeguards to your list that have been identified by other students.
10. Practice the procedure again with emphasis on the safeguards identified. Have a fellow student critique your performance.
11. Have your instructor evaluate your performance in a simulated setting.
12. Complete the checksheet.

Name____________________

Date____________________

PERFORMANCE CHECK

Unit XII, Module A, Task 2

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Check physician's order.		
2. Assemble equipment and supplies.		
3. Identify patient and explain procedure.		
4. Position patient.		
5. Wash hands.		
6. Turn on suction machine.		
7. To suction nasal passage:		
a. Moisten catheter and insert catheter into nostril.		
b. Close suction valve.		
c. Suction approximately 15 seconds.		
d. Release suction valve.		
e. Remove and rinse catheter. Repeat process, if necessary.		
f. Repeat process for second nostril.		
8. To suction throat:		
a. Moisten catheter tip and insert catheter into throat.		
b. Repeat steps 7b through 7e.		
c. Give mouth care.		
9. Provide for patient's comfort.		
10. Tidy area		
11. Record procedure, patient's tolerance, and pertinent observations.		

UNIT XIII

CARING FOR THE RESPIRATORY TRACT (TRACHEOSTOMY)

Terminal Objectives

Upon completion of modules in this unit, you will:

- Suction a tracheostomy.
- Remove, clean and replace the inner cannula of a tracheostomy.

Student Competency Sheet

Unit XIII: CARING FOR THE RESPIRATORY TRACT (TRACHEOSTOMY)

Module A: Tracheostomy Care

Task 1: SUCTION TRACHEOSTOMY (This task appears as step 11 in Task 2 of this module. Learning activities are closely related and can be readily combined.)

Performance Checklist

1. Check physician's orders.
2. Identify patient and explain procedure.
3. Position patient.
4. Check equipment and supplies.
5. Wash hands.
6. Put on sterile glove or gloves, if applicable.
7. Turn on suction machine.
8. Ask patient to cough, if possible.
9. To suction tracheostomy:
   a. Moisten catheter tip and insert catheter into tracheostomy tube.
   b. Close suction valve.
   c. Suction tracheostomy.
   d. Release valve and withdraw catheter from tracheostomy tube.
   e. Turn off suction machine.
10. Change tracheostomy dressing, if necessary.
11. Remove glove(s).
12. Provide for patient's comfort.
13. Dispose of catheter.
14. Tidy area.
15. Record procedure.

Test

Items Needed:
1. Patient with a tracheostomy
2. Physician's orders
3. Sterile glove(s)
4. Suction machine

Test: Suction the tracheostomy

Standard:
1. Secretions must be removed.
2. The patient's airway must be maintained.
3. The patient's respiratory passages must not be injured.

Learning Activities

1. Read all available readings from task 2 of this module.

2. Read page 413, Fundamental Skills In Patient Care, and identify the steps and equipment pictured.

3. Observe this task,as demonstrated by your instructor in the laboratory.

4. Observe this task, as demonstrated by your instructor (or other nursing personnel) in a maximum care unit.

5. Practice this procedure in a simulated situation in the laboratory.*

6. Have your instructor evaluate your performance of this task in a simulated patient care situation.

7. Perform this task, as assigned by your instructor, in the clinical setting.

8. In a class discussion, review the topic of Tracheobronchial Suction, Clinical Nursing Techniques, 3rd Ed.,pages 115-117.

9. Review the policy and procedure for tracheobronchial suctioning at your teaching hospital(s), as provided by your instructor.

*NOTE: This task may be practiced separately or as a portion of task 2 to follow. Your instructor will identify the best method for laboratory practice for this procedure.

Student Competency Sheet

Unit XIII: CARING FOR THE RESPIRATORY TRACT (TRACHEOSTOMY)

Module A: Tracheostomy Care

Task 2: CLEAN INNER CANNULA OF TRACHEOSTOMY

Performance Checklist

1. Check physician's orders.
2. Identify patient and explain procedure.
3. Assemble equipment and supplies.
4. Wash hands.
5. Provide for privacy and position patient.*
6. Turn the lock to release inner cannula.
7. Remove inner cannula while securing the outer cannula with the other hand.
8. Wash inner cannula well with cold distilled water.
9. Immerse inner cannula in basin of hydrogen peroxide or other prescribed solution.
10. Rinse inner cannula.
11. Suction any secretions from outer cannula.
12. Reinsert inner cannula and lock into place.
13. Change tracheostomy dressing, as ordered.
14. Record procedure.
15. Record patient's tolerance of the procedure.

*NOTE: Closely observe the patient throughout the procedure.

Test

Items Needed:
1. Patient with a tracheostomy
2. Physician's orders
3. Inner cannula
4. Basin
5. Hydrogen peroxide or other prescribed solution
6. Dressings
7. Equipment

Task: Remove, clean and replace the inner cannula.

Standard:
1. The inner cannula must be free of secretions, crust and lint when replaced.
2. The patient's airway must be maintained.
3. The patient's respiratory passages must not be injured.

Learning Activities

1. Read, as available, pages 117-121, Clinical Nursing Techniques, 3rd. Ed. Pay close attention to the illustration on page 118. Also read pages 411-413, Fundamental Skills in Patient Care, and pages 193-194, Total Patient Care, 4th Ed.
2. Enter the following terms in your vocabulary notebook: trachea, tracheostoma, tracheostomy, tracheotomy. Check all definitions with the listed readings or with your instructor.

3. View, as available, the following filmstrips:
   "The Human Respiratory System" - Bell & Howell Filmstrips
   "Endo Tracheal Intubation and Tracheostomy Care" - Career Aids
4. As directed by your instructor, form small discussion groups. Immediately after viewing a filmstrip illustrating tracheostomy care, explain your responses to your learning/discussion group.
5. Summarize the responses and report back to the larger group.
6. Attend the lecture/demonstration of this task in the learning laboratory.
7. Attend a discussion led by your instructor regarding the psychological response of the patient to (a) respiratory distress,(b) the need for a tracheostomy.
8. Practice this task with a fellow student using the laboratory mannequin.
9. Have your instructor evaluate your performance in the laboratory based upon the Performance Checklist and stated standards.
10. Observe the performance of this procedure, in the clinical setting, by your instructor or other nursing personnel.
11. As assigned by your instructor, complete this task in an actual patient care situation.
12. Have your instructor supervise and evaluate your performance.

UNIT XIV

CARING FOR THE EYE, EAR, NOSE & THROAT

Terminal Objectives

Upon completion of modules in this unit, you will:

- Irrigate a patient's throat with a prescribed solution without injury to mucous membranes.
- Use a catheter to irrigate a patient's nasal cavity.
- Use a syringe to irrigate a patient's ear(s) to remove cerumen or a foreign object.
- Irrigate a patient's eye(s) with a prescribed solution.

Student Competency Sheet

Unit XIV: CARING FOR THE EYE, EAR, NOSE & THROAT

Module A: Throat Care

Task 1: IRRIGATE THROAT

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Establish a signal for interrupting the irrigation to maintain patient comfort.
5. Wash hands.
6. Prepare irrigation solution.
7. Position container with prescribed solution. Position patient.
8. Insert nozzle or catheter to back of mouth.
9. Unclamp tubing and allow solution to flow.
10. Interrupt irrigation at preplanned signal.
11. Continue to alternate irrigation and interruption, as necessary.
12. Provide for patient's comfort.
13. Remove equipment and supplies.
14. Tidy area.
15. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Prescribed solution
4. Catheter
5. Towel

Task: Irrigate the patient's throat.

Standard:
1. The entire throat must be irrigated using the prescribed irrigation solution.
2. The irrigation and interruption signals must be coordinated.
3. Mucous membranes must not be injured.

Learning Activities

1. Read pages 296-297, Clinical Nursing Techniques, 3rd Ed.
   Read pages 156-160, 187-190, Nursing Skills for Allied Health Services, Vol. 3-Unit 4.

2. Read clinical nursing procedure manual to determine proper charting of procedure for your teaching institutions.

3. Observe a demonstration by your instructor in the learning laboratory.

4. Practice assuming the position necessary for a throat irrigation.

5. Practice assisting a fellow student to assume the position necessary for a throat irrigation.

6. Discuss with a fellow student your response to this position and sensations that might occur during this procedure.

7. With a fellow student as a partner, practice this procedure.

8. Have your instructor evaluate your performance of this task in the laboratory and in the clinical setting.

Student Competency Sheet

Unit XIV: CARING FOR THE EYE, EAR, NOSE & THROAT

Module B: Care of the Nasal Passages

Task 1: IRRIGATE NOSE

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Position and drape patient.
5. Wash hands.
6. Prepare irrigation solution.
7. Position irrigation container with prescribed solution.
8. Insert catheter or nozzle into nostril.
9. Unclamp tubing and allow solution to flow.
10. Clamp tubing and transfer nozzle to other nostril and repeat procedure.
11. Clamp tubing and remove catheter or nozzle.
12. Remove equipment and supplies.
13. Provide for patient's comfort.
14. Tidy area.
15. Record procedure.

Test

Items Needed:

1. Patient
2. Physician's orders
3. Irrigation solution
4. Irrigation container
5. Catheter

Task: Irrigate the patient's nasal cavity.

Standard:

1. The irrigation solution must be at room temperature.
2. If warm solution is ordered, the temperature must not exceed 105°F (40.5°C).
3. The nasal cavity must be free of crusts and drainage.

Learning Activities

1. Read pages 182-185, Nursing Skills For Allied Health Services, Vol. 3-Unit 4.
2. View the filmstrip "The Human Respiratory System" - Bell & Howell Filmstrips - to review the structure of the nose and the nasopharynx.
3. Observe a demonstration of this task by your instructor.

4. Read, carefully, directions accompanying disposable irrigation kits that may be used for this procedure at your teaching hospital(s)/agencies.

5. Identify equipment needed for this task.

6. With a fellow student, practice this procedure using the laboratory mannequin as the patient.

7. Using the Performance Checklist, have your learning partner critique your performance.

8. Prepare to be evaluated in your performance of this task.

9. Have your instructor evaluate your performance 1) in a simulated situation, 2) in an actual patient care situation.

Student Competency Sheet

Unit XIV: CARING FOR THE EYE, EAR, NOSE & THROAT

Module C: Ear Care

Task 1: IRRIGATE EAR(S)

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Wash hands.
4. Prepare irrigation solution at 105°F (40.5°C), unless otherwise ordered.
5. Identify patient and explain procedure.
6. Position and drape patient.
7. Instruct patient to hold drainage receptacle under the ear and against the neck.
8. Pull ear lobe up and back to straighten auditory canal.
9. Instruct patient to tilt head toward drainage receptacle.
10. Insert syringe tip just past the entrance of the external meatus.
11. Instill irrigation solution upward and backward into ear.
12. Repeat procedure until solution returns clear or until foreign object is removed.
13. Provide for patient's comfort.
14. Tidy area.
15. Record procedure.
16. Record patient's tolerance of procedure.

Test

Items Needed:
1. Adult patient
2. Physician's orders
3. Irrigation solution
4. Drainage receptacle
5. Syringe

Task: Irrigate the patient's ear(s).

Standard: The cerumen or foreign object must be removed without further injury to the ear.

Learning Activities

1. Read pages 172-176, "Item 6: Irrigation of Ear"; page 203, "Ear Irrigation"; Nursing Skills for Allied Health Services, Vol. 3. Read pages 706-708, "Guidelines: Irrigating the External Auditory Canal," The Lippincott Manual of Nursing Practice.

2. Review anatomy of the ear.

3. Attend lecture and demonstration using mannequin.

4. Observe and manipulate various types of equipment used for irrigation of ear.
5. Read teaching hospital's manual procedure for "Irrigation of Ear."
6. Practice performance with mannequin in laboratory.
7. Practice performance in agency setting, with instructor's supervision.

Student Competency Sheet

Unit XIV: CARING FOR THE EYE, EAR, NOSE & THROAT

Module D: Eye Care

Task 1: IRRIGATE EYE(S)

Performance Checklist

1. Check physician's orders.
2. Explain procedure.
3. Identify patient and explain procedure.
4. Position and drape patient lying on affected side.
5. Wash hands.
6. Prepare irrigation solution.
7. Open sterile supplies.
8. Cleanse eyelid with moistened wipe, as necessary.
9. Lift upper eyelid upward.
10. Administer solution to eye at nasal edge.
11. Allow solution to flow across eye to outer edge of eye into receptable.
12. Continue irrigation until solution is used.
13. Remove equipment and supplies.
14. Provide for patient's comfort.
15. Tidy area.
16. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Irrigation solution
4. Wipe
5. Drainage receptacle

Task: Irrigate the patient's eye(s).

Standard:
1. The prescribed solution must be used for irrigation.
2. The prescribed solution must be administered from the nasal edge of the eye, across the eye, to the outer edge of the eye.

Learning Activities

1. Read pages 395-396, Fundamental Skills In Patient Care; and/or pages 293-294, Clinical Nursing Techniques, 3rd Ed.

2. View the following filmstrips:
   "The Sense Organs" - Bell & Howell Filmstrips
   "Eye Disorders" - American Journal of Nursing

3. Prepare a diagram of the eye and the tear duct for your notebook.

4. Attend a lecture/demonstration session illustrating this task and its use in the treatment of eye disorders.

5. Add new terms from the readings or class demonstration to your vocabulary notebook. Have your instructor check all definitions.

6. With a learning partner, list points of explanation that would be helpful to your patient prior to experiencing this treatment.

7. Practice this task in the laboratory. Include an adequate explanation to the patient and incorporate the list you have prepared.

8. Have your instructor evaluate your performance, including your explanation to the patient.

9. As assigned, perform this task in actual patient care situations with your instructor's supervision.

UNIT XV

CARING FOR THE URINARY SYSTEM

Terminal Objectives

Upon completion of modules in this unit, you will:

- Insert a urinary catheter attached to a drainage bag.
- Remove a retention catheter without causing patient discomfort or soil.
- Irrigate a patient's urinary bladder.

Student Competency Sheet

Unit XV: CARING FOR THE URINARY SYSTEM

Module A: Maintaining Urinary Output and Preventing Infection

Task 1: INSERT A URINARY CATHETER

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Wash hands.
5. Position and drape patient.
6. Open catheter tray using sterile technique.
7. Put on sterile gloves.
8. Drape patient with sterile drapes.
9. Expose and cleanse meatus and surrounding area.
10. Lift catheter from tray.
11. Lubricate catheter.
12. Insert catheter into urinary meatus.
    a. Retention catheter:
        (1) Inflate catheter balloon.
        (2) Connect catheter to drainage bag and secure bag.
        (3) Secure catheter.
    b. Straight catheter:
        (1) Drain bladder or collect specimen, as applicable.
        (2) Remove catheter.
13. Provide for patient's comfort.
14. Tidy area.
15. Record procedure.
16. Record patient's tolerance of procedure.
17. Record initial urinary output.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Catheter tray
4. Sterile drapes
5. Lubricant
6. Drainage bag

Task:
1. Insert a urinary cathether.
2. Attach the catheter to a drainage bag, if necessary.

Standard:
1. Asceptic techniques must be used and maintained when handling the catheter.
2. Tissue must not be damaged or irritated.
3. Patient comfort and privacy must be maintained.
4. All items on the checksheet must be rated acceptable.

Learning Activities

1. Read "Surgical Asepsis - Gloving and Handling Sterile Supplies," Nursing Skills for Allied Health Services, Vol. III, 1st Ed., pages 8-10; Item 5, pages 26-28; and Item 7, pages 31-34. Also read "Urinary Catheterizations," Nursing Skills for Allied Health Services, Vol. III, 1st Ed., Item 1, pages 208-219; and page 463, Lippincott Manual of Nursing Procedures, 1st Ed.
2. Watch filmstrips #432 "Urinary Catheterization" and "Urinary Catheter and Care" by Trainex.
3. Diagram the structure of the urinary system for your notebook.
4. Attend a lecture/demonstration of this procedure and its application.
5. Practice opening a sterile package in the learning lab.
6. Practice inserting a Foley catheter into a female and/or male simulator, using the performance checklist as a guide.
7. Practice attaching catheter to a drainage bag.
8. Practice recording a nurse's notes regarding the procedure.
9. Have your instructor evaluate your performance, in the laboratory, in a simulated patient-care situation.
10. Locate agencies' procedure for urinary catheterization.
11. Locate equipment or packages necessary for performing a catheterization in your teaching hospital(s) or agencies.
12. In the clinical setting, consult with your instructor when reading a physician's order for this procedure.
13. As assigned, perform this task in an actual patient-care situation, with your instructor's supervision.
14. Complete the performance checksheet.

Name____________________________
Date____________________________
Unit XV, Module A, Task 1

PERFORMANCE CHECK

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Check physician's orders.		
2. Assemble equipment and supplies.		
3. Identify patient and explain procedure.		
4. Wash hands.		
5. Position and drape patient.		
6. Open catheter tray using sterile technique.		
7. Put on sterile gloves.		
8. Drape patient with sterile drapes.		
9. Expose and cleanse meatus and surrounding area.		
10. Lift catheter from tray.		
11. Lubricate catheter.		
12. Insert catheter into urinary meatus. a. Retention catheter: (1) Inflate catheter balloon.		
(2) Connect catheter to drainage bag and secure bag.		
(3) Secure catheter.		
b. Straight catheter:		
(1) Drain bladder or collect specimen, as applicable.		
(2) Remove catheter.		
13. Provide for patient's comfort.		
14. Tidy area.		
15. Record procedure.		
16. Record patient's tolerance of procedure.		
17. Record initial urinary output.		

Student Competency Sheet

Unit XV: CARING FOR THE URINARY SYSTEM

Module A: Maintaining Urinary Output and Preventing Infection

Task 2: REMOVE RETENTION CATHETER

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Wash hands.
5. Prepare patient.
6. Place linen savers under patient's hips.
7. Deflate catheter balloon.
8. Remove catheter. CAUTION: Check patency of balloon by reinflating to insure that balloon has not disintegrated leaving residuals in the bladder.
9. Tidy area.
10. Provide for patient's comfort.
11. Record procedure.

Test

Items Needed:
1. Patient with retention catheter.
2. Physician's orders.
3. Linen savers.
4. Retention catheter.

Task: Remove the retention catheter.

Standard:
1. The removal will not cause the patient undue discomfort.
2. The removal will not soil the patient or the bed linens.

Learning Activities

1. Read Item 4, page 219, Nursing Skills for Allied Health Services, Vol. III, 1st Ed.

2. Watch filmstrips by Trainex, #432 "Urinary Catheterization" and "Urinary Catheter and Care."

3. Attend discussion/demonstration class by your instructor.

4. Practice removing a retention catheter, according to performance checklist, using the laboratory mannequin.

5. Practice recording a nurse's notes regarding the above procedure. Have your instructor check your charting (recording) in a simulated situation. Make note of her/his suggestions.

6. Have your instructor evaluate your performance of this procedure in the laboratory and the clinical setting.

Student Competency Sheet

Unit XV: CARING FOR THE URINARY SYSTEM

Module A: Maintaining Urinary Output and Preventing Infection

Task 3: IRRIGATE URINARY BLADDER

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Wash hands.
5. Prepare equipment.
6. Disconnect drainage tube from catheter.
7. Place end of catheter over drainage receptacle.
8. Protect end of drainage tube with sterile cover.
9. Fill irrigating syringe with prescribed amount of sterile solution.
10. Instill solution into catheter.
11. Disconnect syringe and catheter and allow solution to flow into drainage pan.
12. Repeat procedure until fluid returns clear.
13. Reconnect catheter and drainage tube.
14. Provide for patient's comfort.
15. Tidy area.
16. Record procedure.

Test

Items Needed:
1. Patient with indwelling urinary catheter
2. Physician's orders
3. Drainage receptacle
4. Sterile cover
5. Sterile solution
6. Irrigating syringe
7. Cleansing aids

Task: Irrigate the patient's urinary bladder.

Standard: The prescribed amount of irrigation solution must be instilled without contamination.

Learning Activities

1. Read pages 160-164, Nursing Skills for Allied Health Services, Vol. III, 1st Ed.

2. Attend lecture/demonstration class illustrating this task and its application.

3. Identify appropriate irrigating equipment. Compare disposable packets.

4. Practice the procedure with the equipment currently in use at your hospital or agency.

5. Demonstrate bladder irrigation, using aseptic technique, according to performance checklist for a fellow student.

6. Practice recording nurse's notes concerning the procedure and the patient's response.

7. Have your instructor evaluate your performance of this task.

UNIT XVI

CARING FOR THE GASTRO-INTESTINAL SYSTEM

Terminal Objectives

Upon completion of modules in this unit, you will:

- Feed a patient through a gavage tube.
- Connect a nasogastric tube to a drainage bottle so that drainage will be maintained.
- Irrigate a nasogastric tube.
- Insert a rectal depository.
- Insert a rectal tube.
- Change a colostomy dressing.
- Irrigate a colostomy.

Student Competency Sheet

Unit XVI: CARING FOR THE GASTRO-INTESTINAL SYSTEM

Module A: Upper Gastro-Intestinal System

Task 1: ADMINISTER GAVAGE FEEDINGS

Performance Checklist

1. Check physician's orders.
2. Wash hands.
3. Assemble equipment and supplies.
4. Warm formula to room temperature.
5. Identify patient and explain procedure.
6. Elevate patient's head, if possible.
7. Unclamp and check placement of gavage tube before feeding.
8. Insert feeding syringe tip into tube.
9. Clear tube with 1-2 oz. of tap water.
10. Pour formula into syringe.
11. Allow formula to flow by gravity pull.
12. Clear tube with 1-2 oz. of tap water.
13. Clamp tube.
14. Remove and clean equipment.
15. Provide for patient's comfort.
16. Record procedure.
17. Record intake of gavage feeding.
18. Record patient's tolerance of procedure.

NOTE: If gavage tube is to be removed, clamp tube, pull out slowly, and dispose of tube.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Formula
4. Gavage tube
5. Feeding syringe tip
6. Towel
7. Wash receptacle

Task: Feed the patient through the gavage tube.

Standard:
1. Placement and patency of the gavage tube must be checked before feeding.
2. The formula must flow by gravity pull.
3. The patient's condition must be checked frequently throughout the procedure.

Learning Activities

1. Read page 299, Total Patient Care, 4th Ed.; pages 545-546, 556-559, Nursing Skills for Allied Health Services, Vol. II, 2nd. ed., Unit 26. (1st. ed. Vol. II, pages 507-510); pages 395-399, Lippincott Manual of Nursing Practice.

2. View the following filmstrips:
   "The Human Digestive System" - Bell & Howell filmstrips.
   "Nasogastric Intubation and Gavage Feeding" - TRAINEX.

3. Diagram the upper gastro-intestinal tract for your notebook.

4. Enter new terms and/or structures of the GI tract in your vocabulary notebook. Include the following:

   gavage
   gavage tube
   nasogastic tube
   aspiration
   pyloric sphincter
   esophagus

5. Observe a demonstration of this task by your instructor.

6. Compare disposable packs designed for this procedure. Read, carefully, the directions for the equipment or packs used at your teaching agencies or hospital(s).

7. Attend a lecture/discussion class describing the use of this type of feeding in a variety of patient conditions.

8. Practice this procedure in the learning laboratory.

9. Perform a return demonstration for your instructor. All listed standards must be met.

Student Competency Sheet

Unit XVI: CARING FOR THE GASTRO-INTESTINAL SYSTEM

Module A: Upper Gastro-Intestinal System

Task 2: CONNECT NASOGASTRIC TUBE TO SUCTION

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies. Check suction machine.
3. Identify patient and explain procedure.
4. Place suction machine in a safe and convenient spot.
5. Wash hands.
6. Connect nasogastric tube from patient to the drainage bottle.
7. Plug in suction machine.
8. Turn on machine.
9. Check machine frequently to be sure it is properly removing drainage. Check the patient's condition frequently.
10. Empty suction bottle as follows:
    a. Turn off machine.
    b. Remove suction bottle top.
    c. Measure contents in graduated measuring pitcher.
    d. Rinse bottle and pitcher.
    e. Replace suction bottle top.
    f. Turn on machine.
11. Provide for patient's comfort.
12. Tidy area.
13. Record procedure.

Test

Items Needed: 1. Patient with a nasogastric tube inserted
2. Physician's orders
3. Suction machine
4. Suction bottle
5. Drainage bottle
6. Graduated measuring pitcher

Task: 1. Connect the nasogastric tube to the drainage bottle.
2. Maintain the drainage with suction.

Standard: 1. The nasogastric tubing must be securely connected.
2. There must be no kinks in the tubing
3. Drainage must be maintained.

Learning Activities

1. Read pages 563-564, Nursing Skills for Allied Health Services, Vol. II, 2nd ed. Unit 26. (1st ed., Vol. II, pages 502-504)

2. View "GI Drainage By Suction" - Lippincott Filmloops,
   "Gastric and Gastro Intestinal Decompression" - TRAINEX
3. Attend a lecture/discussion class describing the types of equipment used in your teaching hospital(s)/agencies for this procedure.
4. Observe a demonstration of this task, by your instructor, in the laboratory or clinical setting.
5. In small groups, investigate the suction apparatus used for this procedure. Read directions carefully and examine the equipment.
6. Practice the procedure in the learning laboratory.
7. In simulated situations, provided by your instructor, practice measuring, observing, and recording the contents of the suction bottle.
8. Have your instructor evaluate your performance in the laboratory and in actual patient care situations. The checklist and stated standards will be used as guidelines.

Student Competency Sheet

Unit XVI: CARING FOR THE GASTRO-INTESTINAL SYSTEM

Module A: Upper Gastro-Intestinal System

Task 3: IRRIGATE NASOGASTRIC TUBING FOR PATENCY

Performance Checklist

1. Check physician's orders.
2. Assemble equipment.
3. Identify patient and explain procedure.
4. Wash hands and prepare equipment.
5. Check placement of nasogastric tube.
6. Open free end of tube or disconnect from suction machine.
7. Use syringe to inject prescribed solution into tube.
8. Allow return solution to flow by gravity into receptacle.
9. Observe returned solution for amount, color, consistency and odor.
10. Repeat procedure, as necessary.
11. Remove irrigation syringe and clamp end of tube or attach to suction machine.
12. Provide for patient's comfort.
13. Tidy area.
14. Record procedure, patient's response, and description of solution returned.

Test

Items Needed:	1. Patient in which a nasogastric tube has been inserted 2. Physician's orders 3. Syringe 4. Prescribed solution 5. Drainage receptacle
Task:	Irrigate the nasogastric tube.
Standard:	1. Installation of the prescribed irrigation solution must be slow and allowed to return by gravity flow. 2. Record observation of amount, color and odor and consistency. 3. Patient's condition must be assessed during procedure.

Learning Activities

1. Read pages 552-553, Nursing Skills for Allied Health Services, Vol. II, 2nd ed., Unit 26. (1st ed., Vol. II, pages 498-504.)

2. Review TRAINEX Filmstrip "Nasogastic Intubation and Gavage Feeding," if necessary.

3. Observe a demonstration, by your instructor, of this procedure.

4. Practice the task, in the laboratory, using the mannequin as the patient. Include your explanation to the patient.

5. Have your instructor evaluate your performance, based upon the checklist, in a simulated situation and in an actual patient care situation.

Student Competency Sheet

Unit XVI: CARING FOR THE GASTRO-INTESTINAL SYSTEM

Module B: Lower Gastro-Intestinal System

Task 1: INSERT RECTAL SUPPOSITORY

Performance Checklist

1. Check physician's orders with patient's medication record.
2. Assemble supplies.
3. Wash hands.
4. Select medication and check label.
5. Prepare medication.
6. Identify patient and explain procedure.
7. Provide for patient's privacy.
8. Position patient and bed.
9. Put on glove. Apply lubricant.
10. Insert suppository beyond the internal anal sphincter directed against the rectal mucuosa.
11. Remove and dispose of glove.
12. Wash hands.
13. Provide for patient's comfort.
14. Tidy area.
15. Record procedure and pertinent observations.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Rectal suppository
4. Patient's medication record
5. Gloves and lubricant
6. Cleansing aids

Task: Insert a rectal suppository.

Standard: The suppository must be inserted beyond the internal anal sphincter.

Learning Activities

1. Read pages 402-404, "Item 13. Procedure for Insertion of Rectal Suppositories," Nursing Skills for Allied Health Services, Vol. I, 2nd ed. (1st ed. Vol. II, pages 446-449)

2. Review anatomy of lower gastro-intestinal tract.

3. Attend lecture/demonstration using mannequin to show proper techniques for insertion of rectal suppository.

4. Practice the procedure in the laboratory with the mannequin as the patient.

5. Read procedure for insertion of rectal suppository in procedure manuals of teaching hospital(s) or agencies.

6. Have your instructor evaluate your performance of this task in the laboratory. The checklist and stated standards will be the guidelines.

7. Identify, with the assistance of your instructor, medications that are most frequently administered by this mode. Why is this mode of administration sometimes preferred?

8. Practice performance in agency setting; insert rectal suppository with instructor's supervision.

Student Competency Sheet

Unit XVI: CARING FOR THE GASTRO-INTESTINAL SYSTEM

Module B: Lower Gastro-Intestinal System

Task 2: INSERT RECTAL TUBE

Performance Checklist

1. Wash hands.
2. Identify patient.
3. Explain procedure.
4. Position patient on side with one knee flexed.
5. Lubricate tube.
6. Encourage patient to take deep breath as tube is inserted.
7. Insert tube about 4 inches.
8. Wrap free end of tube in towel.
9. Remove tube in 30 minutes or less.
10. Cleanse patient's rectal area.
11. Clean supplies. Wash hands.
12. Report procedure and results.

Test

Items Needed:
1. Rectal tube
2. Lubricant
3. Hand towel
4. Instructions to insert a rectal tube for the release of flatus

Task: Insert a rectal tube.

Standard:
1. The patient must be accorded privacy and comfort.
2. The tube must be removed in the prescribed time.

Learning Activities

1. Read page 405, "Item 16. Use of Rectal Tube for Release of Flatus," Nursing Skills for Allied Health Services, Vol. I, 2nd ed. (1st ed., Vol. II, page 456)

2. Review anatomy of lower gastro-intestinal tract.

3. Attend a lecture/demonstration using the mannequin as the patient.

4. Practice performance using the mannequin.

5. Attend a lecture/discussion class describing medical and surgical conditions that may warrant utilization of a rectal tube.

6. Have your instructor evaluate your performance in the laboratory. The checklist and stated standards will be the guidelines.

7. Practice performance in agency setting with instructor's supervision. Note his/her suggestions.

8. Have your instructor evaluate your performance of this procedure in an actual patient care situation.

Student Competency Sheet

Unit XVI: CARING FOR THE GASTRO-INTESTINAL SYSTEM

Module B: Lower Gastro-Intestinal System

Task 3: CHANGE COLOSTOMY DRESSING

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Wash hands.
5. Provide for privacy and drape patient.
6. Remove and dispose of soiled dressing. Note drainage and/or passage of fecal material.
7. Cleanse area.
8. Inspect stoma for irritation.
9. Apply prescribed lubricant.
10. Apply clean dressing.
11. Secure dressing.
12. Provide for patient's comfort.
13. Tidy area.
14. Record procedure and pertinent observations.

Test

Items Needed:
1. Patient with colostomy
2. Physician's orders
3. Sheet
4. Lubricant
5. Dressing
6. Waste receptacle

Task: Change the colostomy dressing.

Standard:
1. The soiled dressing must be removed and disposed of.
2. The stoma must be cleansed, inspected for irritation and lubricated.
3. The clean dressing must cover the stoma.
4. Drainage and/or passage of fecal material must be accurately recorded.

Learning Activities

1. Read pages 410-412,"Item 22, Colostomies and Ileostomies," Nursing Skills for Allied Health Services, Vol. I, 2nd ed. (1st ed. Vol. II, pages 456-458.) and/or pages 304-307, "Colostomy and Ileostomy Nursing Care,"Total Patient Care, 4th ed. and/or pages 541-542,"Cancer of the Bowel - Postoperative Care," pages 760-761, Modern Bedside Nursing, 8th ed.

2. View filmstrips: "Colostomy Care," TRAINEX, #Hi 268, I - 268.

3. Immediately after viewing the filmstrip, discuss your response with a small learning group. How can these accounts help you to understand your patient's response to a colostomy, as well as your own?

4. Review anatomy and physiology of the large intestines. Name all segments of the large intestines.

5. Attend a lecture/demonstration using the mannequin as the patient.

6. Practice performance using the laboratory mannequin.

7. Role play teaching and explaining treatment to the patient with a new colostomy. List points of explanation that seem important to include. Identify patient's response and questions in the role play situation.

8. Practice performance in agency setting with instructor's supervision. Have your instructor evaluate your performance.

Student Competency Sheet

Unit XVI: CARING FOR THE GASTRO-INTESTINAL SYSTEM

Module B: Lower Gastro-Intestinal System

Task 4: IRRIGATE COLOSTOMY

Performance Checklist

1. Check physician's orders.
2. Assemble equipment and supplies.
3. Identify patient and explain procedure.
4. Wash hands.
5. Provide for the patient's privacy.
6. Position patient and protect bed, if indicated.
7. Attach irrigating bag over stoma.
8. Position irrigation container with prescribed solution 12-18 inches above colostomy.
9. Expel air from tubing and clamp.
10. Lubricate catheter tip.
11. Insert catheter into stoma.
12. Unclamp tubing and allow solution to flow.
13. Clamp and remove tubing and allow material to return to commode bedpan.
14. Repeat procedure, as ordered.
15. Cleanse and dry stoma and surrounding skin. Observe for irritation.
16. Apply new dressing or ostomy appliance.
17. Remove and clean equipment.
18. Provide for patient's comfort.
19. Record procedure and pertinent observations.

Test

Items Needed:
1. Patient with a colostomy
2. Physician's orders
3. Irrigating bag
4. Irrigation container
5. Prescribed solution
6. Lubricant
7. Catheter
8. Cleansing aids
9. Dressing or ostomy appliance

Task: Irrigate the colostomy.

Standard:
1. The irrigation solution temperature must be between 100°-105°F (37.7°-40.5°C).
2. No more than 500 cc's of the irrigation solution must be administered before allowing it to return.
3. The patient's comfort and condition must be continually assessed.

Learning Activities

1. Read:
    - a. Pages 457-458, "Colostomy Care, Item 22," Nursing Skills for Allied Health Services, 2nd. ed.
    - b. Pages 410-412, "Cancer of the Colon," The Lippincott Manual of Nursing Practice.
    - c. Pages 304-307, "Colostomy and Ileostomy Nursing Care," Total Patient Care, 4th ed.
    - d. Pages 413-415, Nursing Skills for Allied Health Services, Vol. I, 2nd ed. (1st ed., Vol. II pages 458-461).
    - e. Pages 414-417, "Irrigating a Colostomy," The Lippincott Manual of Nursing Practice.
2. Attend lecture/demonstration using models of ostomy sites and various types of appliances.
3. Identify solutions commonly used for colostomy irrigation.
4. Observe a demonstration of a colostomy irrigation in the laboratory or clinical setting.
5. View:
    - a. "Colostomy - Series III" - Concept Media
    - b. "Colostomy Irrigation" - TRAINEX #433
6. Practice the procedure in the laboratory, using the mannequin as the patient. Initially, it may be helpful to work with a learning partner.
7. Have your instructor supervise and evaluate your work in the laboratory. Note his/her suggestions.
8. Attend a lecture/demonstration by an enterostomy therapist provided by your school or local ostomy association.
9. As assigned, perform this procedure in an actual patient care situation. Your instructor will evaluate your performance based upon the checklist and task standards.

UNIT XVII

CARING FOR THE REPRODUCTIVE SYSTEM

Terminal Objectives

Upon completion of modules in this unit, you will:

- Insert vaginal medication.

Student Competency Sheet

Unit XVII: CARING FOR THE REPRODUCTIVE SYSTEM

Module A: Gynecological Care

Task 1: INSERT VAGINAL MEDICATION

Performance Checklist

1. Check physician's orders with patient's medication record.
2. Assemble equipment and supplies.
3. Wash hands.
4. Select medication and check label.
5. Prepare medication.
6. Identify patient and explain procedure.
7. Provide for patient's privacy.
8. Position and drape patient.
9. Put on gloves.
10. Separate labia and insert plunger and/or suppository 2"-3" into vaginal canal.
11. Remove plunger, if used, and cleanse.
12. Remove and discard gloves.
13. Provide patient's comfort. Give appropriate instructions for positioning or activity.
14. Tidy area.
15. Record procedure.

Test

Items Needed:
1. Patient
2. Physician's orders
3. Patient's medication record
4. Vaginal medication
5. Gloves
6. Cleansing aids

Task: Insert the vaginal medication.

Standard:
1. The medication must be inserted 2"-3" into the vaginal canal.
2. If appropriate, instructions should be given for positioning or activity following the administration.

Learning Activities

1. Read pages 136-138, Clinical Nursing Techniques, 3rd ed.

2. Review the anatomy of the female reproductive tract, as it applies to this task.

3. Identify structures and positions illustrated on pages 137-138 of the reading in Clinical Nursing Techniques, 3rd ed.

4. Review the filmstrip "Peri Care" - TRAINEX, to assure safe, comfortable care of your client after the medication has been administered.

5. Observe a demonstration of this task by your instructor, in the learning laboratory.

6. Practice the procedure using the laboratory mannequin as the patient.

7. Attend a lecture/discussion class describing the various types of medications that may be administered by this mode and the conditions that might warrant such treatment.

8. Perform this task, with your instructor's supervision, in the laboratory and in an actual patient care situation. Your instructor will evaluate your performance.

UNIT XVIII

PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Terminal Objectives

Upon completion of modules in this unit, you will:

- Interview a patient to obtain and record medical and social history.
- Prepare an incident report of a witnessed accident.
- Record nursing care information on appropriate forms.
- Record and transcribe a physician's orders.
- Develop a functional patient care plan.
- Fill out and route a complete charge slip.
- Carry out emergency evacuation procedures in accordance with established procedures and time limits.
- Inventory and requisition medications.
- Inventory narcotics.
- Prepare requisitions for equipment, supplies or services.
- Orient new employees with the unit and specific job functions.
- Plan and schedule work assignments according to worker competencies and nursing care priorities.

Student Competency Sheet

Unit XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module A: Patient Recording

Task 1: RECORD HISTORY BY PATIENT INTERVIEW

Performance Checklist

1. Assemble appropriate forms.
2. Introduce yourself to the patient.
3. Explain the necessity for obtaining the information.
4. Provide for patient's comfort.
5. Ask applicable questions as outlined on the forms designated by your agency.
6. Record all information.
7. Place completed medical and/or social history forms with patient's records.

Test

Items Needed:
1. Newly admitted patient
2. Medical history forms
3. Social history forms
4. Pens

Task:
1. Interview the patient and obtain and record the patient's medical history.
2. Obtain and record the patient's social history.

Standard:
1. All questions on the forms designated by your facility must be answered.
2. Handwriting must be legible.

Learning Activities

1. a. Read pages 98-100, Fundamental Skills in Patient Care.
   b. Read and study items included on Information Sheet XVIII-A-1, "Nurse's Admission History."
   c. Read Information Sheet XVIII-A-1a, "Policy and Procedure Example."

2. View filmstrips "The Patient as a Person Series" - TRAINEX
   "Admissions and Discharges" - TRAINEX #374
   "Non-Verbal-Verbal Communications" - Concept Media

3. Visit Admission Office in hospital and observe Admitting Nurse interviewing patients and completing admission histories.

4. Practice these interviewing techniques in role play situations provided by your instructor. Utilize the Nurse's Admission History, provided as an information sheet, for this task (Information Sheet XVIII-A-1).

5. Participate in the role play situations as both a patient and a member of the nursing team. Record your responses for use in small or large group discussion.

6. Have your instructor critique your performance in the interview situations.

7. Record patient histories by interview in the clinical setting. Your instructor will supervise you and evaluate your performance.

INFORMATION SHEET

XVIII-A-1

NURSE'S ADMISSION HISTORY

Name Age Admission Date	Time am/pm
How arrived: ☐ ambulatory ☐ wheelchair ☐ stretcher	TPR
From where: ☐ Admitting ☐ ER ☐ Lab ☐ X-ray ☐ Recovery Room	BP
☐ Orders obtained ☐ Doctor notified	Wt. verbal scales
☐ Information obtained from patient ☐ Other	Ht. verbal scales
SOCIAL: In emergency contact	Phone
If unable to contact the above	Phone

CHIEF COMPLAINT: (include general observation and appearance)

PRESENT ILLNESS AND PAST MEDICAL HISTORY (If the answer is yes, you must make a comment)

NO	YES		COMMENTS
☐	☐	Are you or have you ever been on a special diet?	
☐	☐	Do you have any food problems?	
☐	☐	Have you taken medication before?	
☐	☐	Are you taking medication now?	
☐	☐	Do you have any allergies?	
☐	☐	Do you have any other medical problems?	
☐	☐	Have you previously been hospitalized?	
☐	☐	Have you previously had an x-ray?	
☐	☐	Have you previously had an ECG?	

Prosthesis: ☐ glasses ☐ contacts ☐ hearing aid ☐ dentures ☐ limb ☐ other

SLEEP HABITS: BOWEL HABITS:

NO	YES		COMMENTS
☐	☐	Do you live alone?	
☐	☐	Will you be able to make arrangements for your care when you are discharged?	
☐	☐	Will your family/friends be able to visit you?	
☐	☐	Would you like the hospital chaplain to visit you?	
☐	☐	Would you like your minister to visit you?	

REMARKS:

SIGNATURE AND TITLE

INFORMATION SHEET - XVIII-A-1a

POLICY AND PROCEDURE EXAMPLE

NURSING ADMISSION HISTORY AND PHYSICAL

POLICY:

A Nursing Admission History and Physical will be obtained on all admissions. Part II, Review of Systems may be used from previous admissions if within 6 months.

The three part series of questions contain:
(1) the patient's chief complaints
(2) family history
(3) past health history
(4) his profile
(5) present problems
(6) review of systems
(7) source and reliability of the history will be taken by the Admitting Nurse, nurse on the unit and/or the Emergency Room nurse to form the Data Base from which will evolve the patient's problem list and his beginning Nursing Care Plan.

The Nursing Admission History and Physical will be completed as soon as possible after admission and must be completed within 24 hours of the patient's admission. Information will be obtained from the patient, his family, or both by an RN or an LPN.

The Nursing Admission History and Physical will be filed behind the "History and Physical" in the Patient's Medical Record.

EQUIPMENT:

Nursing Admission History Form

PROCEDURE:

Complete all parts in ink. They remain as a permanent part of the Patient Medical Record.

Parts 1 and 3

(1) Stamp with patient's addressograph plate.
(2) Check (X) when indicated.
(3) Include information as noted.
(4) Rephrase questions as indicated, work quickly but allow patient to express himself as indicated.

Part 2 - Review of systems

(1) Write name of patient on line provided.
(2) Allow patient to complete this if he is able.
(3) Discuss the (X) areas as indicated to give a fuller picture of his current status.

Student Competency Sheet

Unit XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module A: Patient Recording

Task 2: PREPARE INCIDENT REPORT

Performance Checklist

1. Obtain written or oral report from all persons involved.
2. Record information on appropriate forms.
3. Obtain signatures of all involved persons.
4. Sign forms.
5. File forms in designated areas.

Test

Items Needed:
1. Situation in which a witnessed accident occurs.
2. Victim
3. Witness(es)
4. Incident report forms (one for victim and one for each witness).

Task: Prepare incident reports on a witnessed accident.

Standard:
1. Victim report must be prepared, dated, and signed.
2. Witness report (one for each witness) must be prepared, dated, and signed.
3. Reports must be completed within the guidelines of agency/hospital policy.

Learning Activities

1. Read pages 84-85, Fundamental Skills in Patient Care.

2. View filmstrip "Nursing Team and the Law" - Career Aids.

3. Read:
   a. Information Sheet XVIII-A-2 (Policy and Procedures Sample: Accident/Incident Report)
   b. Information Sheet XVIII-A-2a (Sample of Accident/Incident Report)
   c. Information Sheet XVIII-A-2b (Sample of Employee Accident Report)

4. Attend a lecture/discussion class illustrating the preparation of incident reports and situations that would require their completion.

5. Prepare simulated incident reports for situations provided by your instructor. Consult your instructor for further clarification of forms.

6. Have your instructor supervise your preparation of an incident report when it is required for an accident or incident in the hospital setting. Your instructor will evaluate your preparation based upon the standards stated in this task.

7. Identify responsibilities related to this task that seem to be threatening to you. Discuss these in your clinical conference group, led by your instructor or a fellow student.

INFORMATION SHEET

XVIII-A-2

POLICY AND PROCEDURE EXAMPLE

ACCIDENT/INCIDENT REPORT

PURPOSE: To compile a method for evaluating and instituting prompt medical attention, if indicated when an accident or incident occurs to patient, employee or visitor.

To maintain data of accidents and incidents for finding recurring patterns so that necessary corrective measures can be instituted, if possible.

POLICY:

1. A complete Accident-Incident report must be made on the correct form (Patient, Employee/Visitor) by the person directly involved or witnessing the occurence.

2. The form must be signed by Supervisor or Department head and doctor and forwarded to Director of Nursing Office.

3. In the event a visitor is involved in an accident or injured in any manner, no matter how unimportant it may seem at the time, an accident form is to be filled out in detail by the department where the accident occurred. The employee filling out the report offers to take the person involved to the Emergency Department to be examined. It is the person's prerogative to say whether they want treatment or not. If they wish to go to the Emergency Department, they will be charged just like any other patient.

4. If treatment is given, the report is signed by the attending personnel and the shift Assistant Director of Nursing and then forwarded to the office of the Director of Nurses as soon as possible.* Also, the Outpatient Ledger is filled out. A very detailed history should be written on the ledger, being sure to note that this patient was injured within the hospital.

5. Failure on part of employee or visitor to follow this procedure will result in private payment.

6. Reports should be made on a patient's article lost or damaged.

7. Any medication error shall be reported on an Accident-Incident Report Form.

*EXCEPTION-DIETARY PERSONNEL: The Accident report is sent back to the Dietary Department for completion and then taken to Nursing Service.

INFORMATION SHEET

XVIII-A-2a

SAMPLE OF "PATIENT ACCIDENT/INCIDENT REPORT"

DATE______________TIME_____________

DIAGNOSIS:____

CONDITION AT TIME OF ACCIDENT: NORMAL___SEDATED_______

SENILE____CHILD____IRRATIONAL____

CONDITION OF AREA: WET FLOOR___SIDERAILS: __UP __DOWN

LIGHTING:___OFF ___ON

DESCRIBE WHAT HAPPENED:____

____

____

____

____

____

EXTENT OF INJURY: ____INJURY ____NO APPARENT INJURY ____FALL ____LACERATION

____SYNCOPE____FRACTURE ____BURN ____ABRASION

TYPE OF INCIDENT: ____MEDICATION ERROR ____DEFECTIVE EQUIPMENT

____TREATMENT ERROR ____IMPROPER IDENTIFICATION

PHYSICIAN NOTIFIED: ___YES ___NO

EXAMINED BY PHYSICIAN ___YES ___NO

___________________________PHYSICIAN'S NAME_______TIME _______________________PLACE

STATEMENT BY PHYSICIAN:

____

____

____

NAME AND TITLE OF WITNESSES (IF ANY)____

NAME AND TITLE OF PERSON PREPARING REPORT____________________________________

(Forward To Director Of Nursing)

INFORMATION SHEET

XVIII-A-2b

SAMPLE OF "EMPLOYEE ACCIDENT REPORT"

DATE OF ACCIDENT________________ TIME OF ACCIDENT______________ AM/PM LOCATION________________

EMPLOYEE'S NAME____

MALE_______________ FEMALE_______________ DEPARTMENT_______________ SHIFT_______________

DESCRIBE WHAT HAPPENED:____

____

____

____

____

____

____

____

TYPE OF INJURY: _______________NO APPARENT INJURY _________LACERATION

_______________SPRAIN _________ABRASION

_______________FRACTURE _________BURN

NAME AND ADDRESS OF WITNESSES: ____

____

REFERRED TO: ______NOT NECESSARY ________HEALTH NURSE ________EMERGENCY ROOM

TREATMENT:____

____

____

WORK RELATED INJURY _______YES ______NO

____

REPORT COMPLETED BY: ____
(NAME)

____
(TITLE)

Student Competency Sheet

Unit XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module A: Patient Recording

Task 3: RECORD NURSING CARE

Performance Checklist

1. Obtain patient's chart.
2. Record:
   a. Date and time.
   b. Nursing care.
   c. Signs and symptoms.
   d. Tests.
   e. Treatments.
   f. Patient's activities and reactions.
3. Sign entry with your initial, last name, and title.

Test

Items Needed:
1. Patient's chart
2. Information regarding:
   a. Nursing care
   b. Observations
   c. Tests
   d. Treatments
   e. Procedures
   f. Situations
3. Form(s)
4. Pen

Task: Record the information on the appropriate form(s).

Standard: All entries must:
1. Indicate exact time of transaction.
2. Be clear, concise, and accurately describe observation, nursing care, tests, treatment, procedure, or situation.
3. Be legible without erasures.
4. Be signed.
5. Comply with hospital/agency format for recording nursing assessment and care.

Learning Activities

1. Review Unit C - Charting, Reporting, Recording.

2. Read:
   a. Pages 98-107, Fundamental Skills in Nursing Care.
   b. Information Sheet XVIII-A-3 (Some Basic Rules for Charting).
   c. Information Sheet XVIII-A-3a (Table of Descriptive Terms).

3. View the following filmstrips:
"Nursing Team and the Law" - Career Aids
"Observation and Charting" - TRAINEX
Make notes of your questions regarding information presented.

4. In small groups, with your instructor, review your questions from the filmstrips.

5. Complete "Charting Exercise #1" (Information Sheet XVIII-A-3b).

6. Complete "Charting Exercise #2" (Information Sheet XVIII-A-3c). The information about Mrs. Reynolds must be charted with 100% accuracy. The standards and the performance checklist will be the guidelines for this instructor-graded activity.

INFORMATION SHEET

XVIII-A-3

SOME BASIC RULES FOR CHARTING

1. Charting should be brief, concise, and accurate using good English and correct spelling.

2. Chart:

   a. Symptoms
   b. Observations
   c. Content of communication with patient if significant
   d. To and from xray, Surgery, PT
   e. Treatment - kind, duration, results, and toleration
   f. Medications - dosage, mode, time, signature
      (1) IMs - site and signature
      (2) IVs - time started, by whom, how administered (needle, infusor), medications added if any, when discontinued, amount absorbed, any untoward effect and any reaction at injection site
   g. Designated areas when applicable such as B/P, intake, output
   h. Diet - kind and how accepted

3. Make sure TIMES are included in the time column.

4. Please stay in column indicated. This makes a neater, more legible and uniform chart.

5. Signing off charts:

   a. Include condition of patient
   b. Signatures: P. Jones, LPN
   c. If oral medications have been initialed above, write name and time (shift)

6. Charts may be written or printed, but must be legible including the signature.

7. Only standard abbreviations and symbols are to be used.

8. Use only blue or black ink.

9. Avoid repetitive phrases.

10. Remember - if it isn't charted - you DID NOT DO IT!

11. The chart is a legal document - treat it as such.

12. Do not skip lines in charting.

INFORMATION SHEET

XVIII-A-3a

TABLE OF DESCRIPTIVE TERMS COMMONLY USED IN CHARTING

Factors to be Charted	Suggested Terms to Use
1. large and extends outward	1. enlarged, protruding
2. black and blue marks present	2. bruised, acchymetic, ecchymosis
3. hard, boardlike	3. hard, rigid
4. soft, flabby, flat	4. relaxed, flaccid, flat
5. hurts when touched	5. sensitive to touch, tender
6. appears swollen, rounded	6. distended
7. presence of rash	7. rash present
8. filled with gas	8. tympanites
9. large amount	9. profuse, copious, free excessive, measured amt. in cc's
10. moderate amount	10. moderate, usual, measured amt.
11. small amount	11. small, scanty, slight
12. thin and undernourished	12. emaciated
13. fat, greatly overweight	13. obese
14. seems very sick	14. acutely ill
15. not very sick	15. in no acute distress

Regions: Examples

1. upper abdomen	1. epigastric region
2. lower back	2. lumbar region
3. mid abdomen	3. umbilical region
4. hip	4. iliac region

(Note: Review anatomical terms for accurate, concise chartings)

Concerning Attitude

1. not interested in surroundings	1. indifferent
2. has "don't care" attitude	2. apathetic
3. doesn't believe anything said	3. suspicious
4. quarrelsome, disagreeable, wants to argue	4. belligerent, disagreeable
5. afraid, worried	5. anxious, fearful
6. seems to have weight-of-world on shoulders	6. very serious minded, depressed
7. happy, carefree, cheerful	7. cheerful, optimistic

INFORMATION SHEET

XVIII-A-3b

CHARTING EXERCISE #1

You are assigned to Mrs. Blake, a 60 year old obese woman, admitted to the hospital for treatment of pneumonia. She is in a weakened condition and requires a complete bath and occupied bed change.

You find Mrs. Blake sitting in bed crying; she tells you she feels terrible, she can not stop coughing and her chest hurts almost constantly. While making her more comfortable, you notice she has a harsh cough that causes her to clutch her chest.

Throughout the bath, you provide her with the emesis basin so she can spit out mucus that she has coughed up. At one point she vomits approximately 300cc of undigested food after a coughing episode.

In observing her skin during the bath you notice a reddened area over her coccyx; you massage the area well and position Mrs. Blake on her side to relieve pressure from her back. After her morning care you take her vital signs (T-100^{6} - P092 R-28 BP-142/90) and report your findings to the charge nurse.

Chart your observations as you would on the Nurse's Notes of the patients' charts in your hospital or agency. Concentrate on being precise and concise; give a clear picture of the patient situation without being wordy.

INFORMATION SHEET

XVIII-A-3c

CHARTING EXERCISE #2

You are assigned to taking vital signs on several patients. You find Mrs. Reynolds' TPR to be 99^{6} - 130 - 22. You note that she appears blue around her mouth and that she is experiencing moderate dyspnea. She is perspiring heavily. You take her BP which is 110/70, then make her as comfortable as possible and report your findings to the charge nurse.

You return to Mrs. Reynolds and assist her into a dry gown. You note that her skin is cool to touch and clammy. She asks for the bedpan; while assisting her, you notice that her ankles appear very swollen and tight. Upon emptying the bedpan, you find a small amount of brownish very concentrated urine.

When returning the bedpan, you find her doctor with Mrs. Reynolds. You answer his questions, then chart your findings on Mrs. Reynolds.

Chart as you would on the charts Nurse's Notes of the patient's chart in your hospital or agency. Be clear and concise.

INFORMATION SHEET

XVIII-A-3d

SAMPLE OF "NURSE'S PROGRESS NOTES"

Initials and Signature/Title					

Date:

Time:	Special Medications & Treatments	Remarks

Name____________________
Date____________________
Unit XVIII, Module A, Task 3

PERFORMANCE CHECK SHEET

ACTIVITY	RATING	
	Acceptable	Unacceptable
1. Obtained Patient Chart		
2. Recorded following information		
a. Date and time		
b. Nursing Care		
c. Signs and symptoms		
d. Treatments		
e. Patient activities and reactions		
3. Signed entry $\bar{c}$ initial, last name, title		

Student Competency Sheet

Unit XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module A: Patient Recording

Task 4: TRANSCRIBE PHYSICIANS ORDERS

Performance Checklist

1. Transcribe "STAT" orders immediately.
2. Request equipment, supplies, medications from appropriate sources.
3. Schedule appointments.
4. Transfer orders to Patient Care Plan medicine kardex, treatment kardex, if applicable.
5. Check-off each order as it is transcribed.
6. Sign or initial physician's orders after they have been transcribed.

Test

Items Needed:
1. Patient's chart
2. Physician's orders
3. Pen
4. Paper or form
5. Telephone
6. Physician
7. Requisition forms
8. Patient Care Plan
9. Medicine kardex
10. Treatment kardex

Task: Transcribe physician's orders.

Standard:
1. Orders must be recorded without error.
2. Orders must be transcribed without error.

Learning Activities

1. Read pages 100-101, "The Patient's Chart as a Legal Document," Fundamental Skills for Patient Care.
   Read pages 29, 100-102, and 164, Concepts in Leadership for the Licensed Practical Nurse, Smith and Huber.

2. View "Nursing Staff Oral Communications" - Career Aids.
   Pay particular attention to the portion describing effective telephone communication.

3. In small groups, or with a learning partner, identify communication skills, both written and oral, that should be developed to facilitate the safe, efficient transcription of written orders.

4. Practice transcribing simulated orders in the laboratory.
5. As assigned, observe a charge nurse transcribe written orders in the hospital/agency setting.
6. As assigned, transcribe written orders with your instructor's supervision.

Student Competency Sheet

Unit XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module B: Patient Processing

Task 1: DEVELOP A PATIENT CARE PLAN

Performance Checklist

1. Analyze situation and identify:
    a. Patient's problems.
    b. Nursing care problems.
2. Review physician's orders.
3. Record suggestions for problem solutions.
4. Record suggestions for patient's plan of care.
5. Discuss patient care plan with instructor.
6. Review and update plan as patient's condition dictates.

Test

Items Needed:
1. Case situation
2. Physician's orders
3. Paper
4. Pencil
5. Care plan form

Task: Develop a patient care plan.

Standard:
1. All pertinent areas of the form must be completed.
2. Contributions from all participating health team members must be encouraged.
3. The plan must be functional and the format conducive to updates.

Learning Activities

1. Read pages 100-102, Fundamental Skills in Nursing Care.

2. View the following filmstrips as available:
"Planning Nursing Care" - Career Aids
"Nursing Staff Oral Communication" - Career Aids
"Understanding the Difficult Patient" - Career Aids
"Non-Verbal-Verbal Communications" - Concept Media
"Nurse-Patient Interaction Series" - Concept Media
"The Patient As A Person Series" - TRAINEX

View in small discussion groups, if possible.

3. Discuss questions that your learning group may have had regarding any of the available filmstrips. Discuss these in the larger group led by your instructor.

4. Read aloud Information Sheet XVIII-B-1 (Policy and Procedure Example - Nursing Care Plan). Discuss each paragraph with your class. Be sure you understand all words and phrases.

5. Locate and compare similar policy and procedure statements from your teaching hospital(s) or agency.

6. Attend a lecture/discussion group led by your instructor describing the use of nursing care plans and the various formats in your teaching hospital(s) or agency.

7. View again any portions of the filmstrips that seemed especially valuable to your understanding of nursing care planning.

8. Practice preparing nursing care plans for simulated situations provided by your instructor.

9. Role play a planning conference involving 4-6 health team members composing a nursing care plan. Have your instructor review your plan and note his/her suggestions.

10. As assigned by your instructor, attend planning conferences in your agency/hospital setting.

11. As assigned by your instructor, update the nursing care plans of patients assigned to you for care. Have all entries checked by your instructor.

12. Your instructor will continue to evaluate your performance based upon the checklist and standards for this task.

INFORMATION SHEET
XVIII-B-1

POLICY AND PROCEDURE EXAMPLE

NURSING CARE PLAN

POLICY:

The nursing care plan is a tool to ensure continuity of nursing care in meeting the total health needs of the patient. It should give evidence that planning has been done to make sure the patient receives appropriate care. It should also serve as an effective method of communicating pertinent information to all nursing personnel concerning the patient.

Plans are developed for each problem and keyed by number and title to the problem list.

The nursing care plan should:

A. Be stated in the form of a direction and include long-range objectives.

B. Identify nursing problems requiring nursing intervention which may or may not be related to a listed patient problem.

C. Provide guidelines to be followed by all nursing personnel as to what nursing measures should be used to accomplish the plan of action.

D. Indicate the standard care routines or principles of nursing care needed by each patient on a daily basis.

E. Outline the goals and approaches to use in planning for discharge.

F. Specify the teaching plans to be used for the patient and/or the family.

All members of the nursing team can then follow a unified and consistent approach in carrying out the nursing plan, evaluate progress in meeting the patient's needs and allow for flexibility to make changes as the patient's condition and needs change.

The RN who does the patient assessment and problems list initiates the patient care plan for each active problem. Continued ongoing planning of patient care ultimately is the responsibility of the RN with the help of her team members. Thus, she must ensure care plans are documented and updated each day.

Discharge plans are considered from the time of admission and are one parameter for teaching and goals during hospitalization. These plans are revised as necessary dependent on the patient's condition, the extent of his family resources and participation along with their expectations for him, and their receptivity to ongoing teaching and counseling by those involved in his health care. Continuity of care which the patient and his family experiences in the hospital through the use of nursing care plans is prolonged into the community with the concurrent goals for discharge apparent from the time of admission.

Student Competency Sheet

Unit XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module B: Patient Processing

Task 2: FILL OUT CHARGE SLIPS

Performance Checklist

1. Using designated equipment, record:
    a. Patient's name
    b. Age
    c. Hospital identification number
    d. Room number
    e. Physician's name
    f. Date
2. Send charge slip to proper department.

NOTE: Charge slip procedures will vary to accommodate facility policies.

Test

Items Needed: 1. List of services to be rendered patient.
2. Charge slips
3. Pencil

Task: Fill out a charge slip for each service provided.

Standard: 1. Charge slips must contain all pertinent information.
2. Charge slips must be sent to appropriate departments.

Learning Activities

1. Read teaching hospital(s) or agency policy and procedure statement regarding charging items supplied to the patient.

2. Attend a demonstration/discussion session led by your instructor, illustrating the use of charge slips in your teaching institutions.

3. Review the various types of charge slips used in the clinical setting.

4. Practice, in the laboratory, the completion of these forms in accordance with the policies provided.

5. Practice using an "Addressograph" or other patient identification system utilized in your hospital or agency.

6. Have your instructor evaluate the forms you have prepared. Note suggestions.

7. As required, complete charge slips with your instructor's supervision, as you use supplies in the delivery of care.

8. Locate central listings, in the clinical setting, that would assist you in determining supplies and equipment that require the completion of charge slips.

9. Discuss this responsibility and the problems that might occur if charge forms are inaccurately completed or overlooked.

Student Competency Sheet

Unit XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module B: PATIENT PROCESSING

Task 3: PRACTICE EVACUATION PROCEDURES

Performance Checklist

1. Orient yourself with evacuation procedures for your facility.
2. Orient other members of the health team involved in carrying out procedures.
3. Coordinate and conduct practice evacuations.
4. Train personnel, as necessary.

Test

Items Needed:
1. Simulated emergency situation.
2. Emergency evacuation plan.
3. Patients and staff.

Task: Carry out emergency evacuation procedures in accordance with established procedures and time limits.

Standard:
1. All persons will be evacuated safely and in accordance with established procedures and time limits.
2. Practice of evacuation techniques and procedures will follow hospital/agency guidelines.

Learning Activities

1. Read, as available, pages 171-173, Concepts in Leadership For The Licensed Practical Nurse, Smith and Huber; pages 575-576, Total Patient Care, 4th Ed.

2. View filmstrip "Emergency Removel of Patients" - TRAINEX #FR 166.

3. Locate and compare the emergency evacuation plans for your teaching hospitals and/or agencies.

4. Attend a lecture/demonstration session, conducted by your instructor or agency safety personnel, describing the periodic drills and practice sessions for emergency evacuation procedures.

5. Practice, under the supervision of your instructor, the following evacuation techniques:
    - one man carry
    - two man carry
    - evacuation of infants
    - evacuation of the patient receiving oxygen therapy

6. As assigned, participate in evacuation drills in the clinical setting. Your instructor will evaluate your performance during these drills.

Student Competency Sheet

Unit XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module C: Inventory Control

Task 1: INVENTORY EQUIPMENT AND SUPPLIES

Performance Checklist

1. Obtain list of items to be inventoried.
2. Obtain appropriate inventory form(s).
3. Organize equipment and supplies so that all like items are together.
4. Count total number of one item.
5. Record total on inventory form.
6. Repeat steps 4 and 5 until inventory is complete.
7. Report and file information.

Test

Items Needed:
1. List of equipment and supplies
2. Inventory form(s)

Task: Inventory the equipment and supplies on your unit.

Standard:
1. Your inventory of the designated equipment and supplies on your unit must be 100% accurate.
2. Inventory reports must be submitted to follow hospital/agency policy.

Learning Activities

1. Locate and read policy and procedure manual guidelines for nursing responsibilities for inventory of unit supplies and equipment.

2. Compare, if possible, the nursing responsibilities at various hospitals and/or agencies.

3. Review inventory forms provided by your instructor for various categories of equipment and supplies.

4. Inventory supplies and equipment in the nursing laboratory, using the forms provided. Be certain to inventory supplies such as linens, dressing supplies, IV solutions, carting supplies, and disposable patient care packets.

5. As assigned by your instructor, assist with an inventory in the clinical setting. Your instructor will evaluate your performance using the checklist and standards for this task.

Student Competency Sheet

Unit XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module C: Inventory Control

Task 2: INVENTORY MEDICINES

Performance Checklist

1. Obtain record of patient's medications.
2. Check name, frequency of administration and dosage of medication against patient's medication record.
3. Determine number or volume of medication remaining.
4. Calculate whether medication is sufficient for prescribed length of time (usually 24 hours).
5. Continue process until all medications for each patient are inventoried.
6. Make list of medications to be reordered.
7. Reorder medications.

Test

Items Needed:
1. Medication for a group of patients
2. Patient's medication records
3. Requisition or order form

Task: Inventory the medications.

Standard:
1. The inventory must correspond with the medication records.
2. The inventory and reorder must comply with hospital/agency policy and procedure.

Learning Activities

1. Read Concepts in Leadership For The Licensed Practical Nurse, pp. 100-103.

2. Locate and compare the policy and procedure guidelines for the inventory of medicines at your teaching hospital(s) and/or agencies.

3. Attend a lecture/discussion session, led by your instructor, defining the responsibilities and legal liabilities of the nurse involved in the inventory and reordering of medicines.

4. Review inventory forms and requisitions supplies by your instructor.

5. In small groups, or with a learning partner, inventory the simulated medication supplies in the nursing laboratory.

6. As assigned, observe and/or assist with the inventory of medications in the clinical setting. Your instructor will evaluate your performance of this task.

Student Competency Sheet

Unit XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module C: Inventory Control

Task 3: INVENTORY NARCOTICS

Performance Checklist

1. Engage assistance of another Licensed Nurse (R.N. or L.P.N. as specified by State and hospital guidelines); usually the medicine nurse of the oncoming shift.
2. Obtain narcotic keys and narcotic register or records.
3. Read aloud the name and strength of the first narcotic as indicated on the record.
4. Have second nurse actually count or measure that narcotic and give exact count or volume.
5. Record actual count of volume in appropriate space on register or record. NOTE: The number or volume must be exactly the same as that indicated on the narcotic record.
6. Repeat steps 3 through 5 until all narcotics are inventoried.
7. Sign your name in appropriate place after inventory.
8. Have other nurse sign also.
9. Secure narcotics and records after inventory.

Test

Items Needed:
1. Supply of narcotics
2. Narcotic register
3. Control records
4. A Licensed Nurse (R.N. or L.P.N. as specified by State and hospital guidelines).

Task: Inventory the narcotics.

Standard:
1. The inventory must have no errors in count or volume.
2. Any discrepency must be reported immediately as specified in hospital or agency policy.

Learning Activities

1. Read pages 34-35, 101-103, and 158, Concepts in Leadership For The Licensed Practical Nurse.

2. Review the policy and procedure statements regarding this task in agency or hospital manual(s).

3. Identify all medications categorized as "controlled drugs" within your teaching hospital(s) or agency.

4. Attend a lecture/demonstration session, led by your instructor, illustrating the narcotic inventory that usually is completed at the end of each 8-hour shift.

5. With a fellow classmate, role play the narcotic inventory in the learning laboratory. Use forms provided by your instructor.

6. As assigned, observe and/or assist with the narcotic inventory in the clinical setting. Your instructor will evaluate your performance of this task.

Student Competency Sheet

XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module C: Inventory Control

Task 4: PREPARE REQUISITIONS FOR EQUIPMENT, SUPPLIES OR SERVICES

Performance Checklist

1. Select appropriate supplies (source), where applicable.
2. Complete heading of requisition.
3. Complete body of requisition.
   a. Quantity
   b. Item description
4. Verify requisition.
5. Send to proper department.

Test

Items Needed:
1. List of supplies and/or equipment.
2. Requisition form.

Task: Prepare a requisition for equipment, supplies, or services.

Standard:
1. All appropriate sections of the requisition form must be properly completed.
2. The requisition must be accurate as to:
   a. Appropriate source.
   b. Quantity.
   c. Item(s) description.
3. The requisition must be sent to the proper department.

Learning Activities

1. Read hospital/agency procedure and policy manual describing nursing responsibilities of requisition preparation.

2. Attend a lecture/demonstration, led by your instructor describing the appropriate use of requisitions such as: pharmacy requisitions, laboratory requisition, x-ray requisitions, central supply requisitions, physical therapy requisitions, and others used in your teaching hospitals or agencies.

3. Add new terms, associated with requisitions for various services or supplies, to your vocabulary note book. You may wish to include hematology, serology, microbiology, urinalysis, nuclear medicine, and other terms new to you. Check your definitions with your instructor.

4. Practice preparing requisitions in the learning laboratory. Have your instructor evaluate those you have prepared.

5. Prepare requisitions, with supervision, as they are necessary in your delivery of patient care. Your instructor will supervise your performance based upon the guidelines and standard of this task.

Student Competency Sheet

Unit XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module D: Employee Supervision

Task 1: ORIENT NEW EMPLOYEES

Performance Checklist

1. Introduce yourself and co-workers to new employee.
2. Acquaint new employee with physical facilities.
3. Acquaint new employee with location of equipment and supplies.
5. Acquaint new employee with institution's policy manual.

Test

Items Needed:
1. New employee
2. List of specific job functions and responsibilities
3. Institution's policy manual

Task: Orient, or familiarize, a new employee with your unit and his/her specific job functions.

Standard: The orientation must include:
1. An introduction to co-workers.
2. A tour of the physical facilities.
3. Location of equipment and supplies.
4. An outline of specific job functions and responsibilities.

Learning Activities

1. Read pages 31-33 and 129-132, "Supervision and the Employee," Concepts in Leadership for the Licensed Practical Nurse.

2. Identify communication skills that would assist the nurse in conducting an efficient and helpful orientation for a new employee.

3. Review those filmstrips and/or learning activities in the previous tasks of this unit that might assist you in evaluating your own communication skills. For example: filmstrip "Nursing Staff Oral Communication" as listed in Task 1, Module B of this unit.

4. As assigned, attend an orientation program at one of your teaching hospital(s) or agencies.

5. Review job descriptions for nursing personnel as they are listed in the policy and procedure manuals of the hospital or agency.

6. Identify information available, to a prospective or new employee, within an institution's job description. How can this be helpful to you in orienting to new employee?

7. Role play the orientation of a new employee, in the learning laboratory. Your instructor will provide situations and details to make the simulation seem more challenging.

8. As assigned, observe or participate in the orientation of a new employee to the clinical setting. Your instructor will evaluate your performance.

Student Competency Sheet

Unit XVIII: PERFORMING SUPERVISED MANAGEMENT PROCEDURES

Module D: Employee Supervision

Task 2: PREPARE PATIENT CARE ASSIGNMENTS

Performance Checklist

1. Review tasks to be accomplished.
2. Review nursing care priorities.
3. Review worker competencies.
4. Assign workers to tasks consistent with their competencies.
5. Assign tasks in order of nursing care priority.

Test

Items Needed:
1. Case situation
2. List of workers and their competencies
3. List of patients
4. List of nursing care priorities

Task: Plan and schedule work assignments according to worker competencies and the nursing care priorities.

Standard:
1. The worker competencies and nursing care priorities must be matched to provide optimal care.
2. Nursing staff communications must facilitate patient care.

Learning Activities

1. Read pages 32-33 (job descriptions), 10-16, and 19-26, Concepts in Leadership for the Licensed Practical Nurse.

2. Review filmstrip "Nursing Staff Oral Communications" - Career Aids and "Planning Nursing Care" - Career Aids.

3. Attend a small group discussion describing the objectives of preparing patient care assignments.

4. Practice preparing assignments for simulated patient care situations provided by your instructor.

5. In small groups, or with two learning partners, review assignments that you have prepared. Offer suggestions and critique each others' solutions.

6. Consult your instructor and consider the basis for the decisions made in planning patient assignments.

7. As assigned, observe a charge nurse prepare patient care assignments and observe the results of this planning. Discuss your observations with your instructor and your clinical conference group.

8. Identify responsibilities associated with this task that may seem threatening to you. Discuss these in clinical conference sessions with your instructor.

9. As assigned, perform this leadership responsibility under the supervision of your instructor. Your performance will be evaluated within the guidelines of the checklist and standards for this task.

10. Use study questions on page 16, Leadership Concepts for the Licensed Practical Nurse, as a self-test. Discuss your answers in small learning groups and consult your instructor for further clarification.